## Consent for Telemedicine and Electronic Communications

I request that the following communications from Joliet Center for Clinical Research (JCCR), be delivered to me by the provided electronic means. I understand that this form of communication may not be secure, creating a risk of improper disclosure to unauthorized individuals. I am willing to accept that risk and will not hold the practice responsible should an incident occur. Please check.

Communications: ____ Appointments and reminders ____ Prescription refill request
___ Billing/ Statements ___ Forms____ Other (List Specifically)__________________________

Method: ____ E-mail ___ Text.

This consent does not expire. If you wish to revoke the consent it must be done IN WRITING. Acknowledgement and agreements; I understand and agree that the requested communication method is not secure, making my PHI (Personal Health Information) at risk for receipt by unauthorized individuals. I accept the risk and will not retaliate against the practice in any way should this occur.

This form and your discussion with your healthcare professional are intended to help you make an informed decision about your telemedicine encounter. A telemedicine encounter is healthcare provided through electronic communications. The health information obtained during a telemedicine encounter may be used for diagnosis, consultation, treatment, therapy, follow-up, or education. Telemedicine encounters should not be used for emergency communications, life threatening conditions, or urgent requests. In signing this document, I acknowledge and agree with the following:

I understand that I will not be physically in the same room as my healthcare professional and that my healthcare professional will be using ZOOM or DOXY.ME. Telephone consultation, videoconferencing, transmission of still images, e-health technologies, patient portals, and remote patient monitoring are all types of electronic communications used for telemedicine encounters.

- I understand that it is my important job to provide an accurate and complete medical history, including all relevant past and present medical conditions, prescription and non-prescription medications, any allergies, recreational drug use, and pregnancy (if applicable).

- My healthcare professional has explained limitations that may exist with a virtual visit, including that I may not be able to receive treatment or diagnosis for the condition which prompted the telemedicine encounter. I understand that in some instances, face- to-face follow-up care may be necessary for further evaluation.

- I understand that there may be potential risks related to the use of this technology,

including interruptions and technical difficulties, such as poor image or sound quality, the inability to conduct certain tests or assessments, delays in treatment due to deficiencies of the technology used, and a lack of access to all relevant medical records which could result in adverse drug interactions or other errors in professional opinion. My healthcare professional will discuss alternate options if it is determined that the electronic communications are not adequate for the situation.

An additional risk inherent to the use of technology is unauthorized access or disclosure of my medical information to someone other than the intended party. The risk of this occurring decreases when a secure connection is used (e.g., home internet, encrypted service) instead of a public internet connection (e.g., public library or coffee shop). [*Option for use of non-public facing technologies during the COVID-19 pandemic*: I understand that my healthcare professional is using Zoom or Doxy.Me and that such technology potentially introduces privacy risks.

- I understand that others may be present during the encounter, such as a consulting healthcare professional or non-medical personnel assisting in the operation of the telemedicine technology, and I consent to their presence.

- If there are any alternatives to a telemedicine encounter, I have had those explained to me (e.g., postponing care, office visit, emergency room visit, etc.).

- I understand that my healthcare information may be shared with other individuals for the purposes of treatment, payment, and healthcare operations, such as scheduling, billing, research and continuity of care.

- I understand that recording of this visit is prohibited, but that I have a right to inspect or obtain a copy of my medical records, or both, after the encounter.

- I understand that I may withhold or withdraw my consent to using telemedicine at any time by contacting the office in writing. I also understand that my refusal or withdrawal will not affect my ability to receive future care or treatment.

- Although telemedicine encounters may be reimbursed by my insurance, I understand that I am responsible for any out-of-pocket costs such as coinsurance or copayments that may apply.

- I understand that a telepsychiatry appointment is scheduled the same as an office appointment would be and I should not be available for the appointment or cancel it less than 24 hours in advance, it will be charged as a missed appointment for the time my practitioner has reserved for a scheduled appointment.

I have been given the opportunity to ask questions about my telemedicine encounter and the associated risks, benefits and practical alternatives to this type of encounter have been explained to me in language that I understand. By signing this document, I acknowledge and accept the possible risks and agree to proceed with a telemedicine encounter.

______________________________________________________________________________

Patient or Legal Representative Signature Date

_________________________________________________

Phone Number (for use in the event the call is disconnected)

______________________________________________________________________________

Address (Note that this asks for the address where you are located to
be used in the case of an emergency situation in which your healthcare provider must contact first responders to assist you.)