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PHONE: 713-773-0803 FAX: 713-271-5422

TELEHEALTH CONSENT FORM

Patient Name_____ **Account No**._____

Address _____

City _____ **State** _____ **Zip** _____

DOB _____ **Sex** _____ **Phone No.** _____

The following information is provided to clients who are seeking Telehealth/Telemedicine services with HOPE Clinic (Asian American Health Coalition). This document covers your rights, risks and benefits associated with receiving services, policies and your authorization. Please read this document carefully, note any questions you would like to discuss and sign.

Telehealth involves the real-time evaluation, diagnosis, consultation on, and treatment of a health condition using advanced telecommunications technology, which may include the use of interactive audio, video, or other electronic media. As such, telehealth allows the provider to see and communicate with the patient in real-time.

Consent for Treatment

I voluntarily request HOPE Clinic providers and physician(s) and such associates, residents, technical assistants and other health care providers as they may deem necessary ("HOPE Clinic Telehealth Providers") to participate in my medical care through the use of telehealth.

I understand that HOPE Clinic Telehealth Providers (i) may practice in a different location than where I present for medical care, (ii) may not have the opportunity to perform an in-person physical examination, and (iii) rely on information provided by me. As such, the the limitations of audio/video technology may limit the elements of physical exam that can be performed due to the nature of audiovisual technologies. I acknowledge that HOPE Clinic Telehealth Providers' advice, recommendations, and/or decision may be based on factors not within their control, such as incomplete or inaccurate data provided by me or distortions of diagnostic images or specimens that may result from electronic transmissions. I acknowledge that it is my responsibility to provide information about my medical history, condition and care that is complete and accurate to the best of my ability. I understand that the practice of medicine is not an exact science and that no warranties or guarantees are made to me as to result or cure.

Possible Limitations: If HOPE Clinic Telehealth Providers determine that the telehealth services do not adequately address my medical needs, they may require an in-person medical evaluation. In the event the telehealth session is interrupted due to a technological problem or equipment failure, alternative means of communication may be implemented, or an in-person medical evaluation may be necessary. If I experience an urgent matter, such as a bad reaction to any treatment or worsening of symptoms after a telehealth session, I should alert my treating physician and, in the case of emergencies dial 911, or go to the nearest hospital emergency department.

Expected Benefits may include: Improved access to medical care by enabling a patient to remain in his/her home or remote site while the provider is at another site; More efficient medical evaluation and management; Obtaining expertise of a distant provider.

Possible Risks: As with any medical procedure, there are potential risks associated with the use of telehealth. These risks include, but may not be limited to: In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the provider and consultant(s); Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment; In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information; •In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors.

Release of Information: To facilitate the provision of care and/or treatment through telehealth, I voluntarily request and authorize the disclosure of all and any part of my medical record (including oral information) to HOPE Clinic Telehealth Providers. I understand and agree that the information I am authorizing to be released may include: 1) AIDS/HIV test results, diagnosis, treatment, and related information: 2) drug screen results and information about drug and alcohol use and treatment; 3) mental health information; and 4) genetic information.

I understand that the disclosure of my medical information to HOPE Clinic Telehealth Providers, including the audio and/or video, will be by electronic transmission. Although precautions are taken to protect the confidentiality of this information by preventing unauthorized review, I understand that electronic transmission of data, video images, and audio is new and developing technology and that confidentiality may be compromised by failures of security safeguards or illegal and improper tampering.

System Security: HOPE Clinic routinely uses secure audio and video technology within the eClinical Works platform. I agree to take full responsibility for the security of any communications or treatment on my own computer or electronic device and in my own physical location. I understand I am solely responsible for maintaining the strict confidentiality of my user ID, password, and/or connectivity link. I shall not allow another person to use my user ID or connectivity link to access services. I also understand that I am responsible for using this technology in a secure and private location so that others cannot hear my conversations.

I understand that there will be no video recording of any of the online sessions and that all information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without my written permission, except where disclosure is required by law.

Consent to Pictures: I understand that it may be necessary during the telehealth visit for the provider or provider office staff to take a picture within the telehealth platform to document my attendance and any condition specific issues (i.e. rash). These pictures will only be used for purposes of documentation within the health record and are not saved by the provider or staff. I consent to have pictures taken for these purposes during the telehealth visit.

I certify that this form has been fully explained to me, that I have read it or have had it read to me, and that I understand its contents and agree to the above information.

_____ _____

Time Date

_____

Signature of Patient or Responsible Party (parent or legal guardian)

_____

Signature of Interpreter/Provider using Telephone Translation Services

_____ _____

Time Date