



**TELEMEDICINE CONSENT**

Telemedicine services involve the use of interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites. I understand and agree to the following:

- The same standard of care applies to a telemedicine visit as applies to an in-person visit.
- I will be notified and consent obtained for anyone other than my healthcare provider present in the room.
- There are potential risks to using technology, including service interruptions, interception and technical difficulties. If the videoconferencing equipment and/or connect is not adequate, my healthcare provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
- I have the right to refuse to participate or decide to stop participating in a telemedicine visit and that my refusal will be document in my medical record. I also understand that my refusal will nto affect my right to future care or treatment.
- The laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
- My health care information may be shared with other individuals for scheduling and billing purposes.
- I will be responsible for any out-of-pocket costs such as copayments or coinsurance that apply to my telemedicine visit. Health plan payment policies for telemedicine visits may be different from policies for in-person visits. My insurance carrier will have access to my medical records for quality review/audit.
- I may revoke this consent at any time by contacting Genesis MD at 210-759-1420.
- This document will become a part of my medical record.

**I have read this form and understand and agree to its contents.**

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Type of Device (iPhone, Android, etc.)

\_\_\_\_\_  
Name of Patient (print)

\_\_\_\_\_  
Date