BLUEGRASS FAMILY ALLERGY

PERSONALIZED ASTHMA & ALLERGY CARE

KELLY S. BRAUER, MD, FACAAI

INFORMED CONSENT FOR TELEMEDICINE SERVICES

I understand that telemedicine is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to provider at *Bluegrass Family Allergy* to provide health care services to me via telemedicine. "Telemedicine" means that you will be evaluated and treated not in person but via electronic communication. Since this may be different than the type of consultation with which you are familiar, it is important you understand and agree to the following statements:

- The consulting health care provider will be at a different location from me. Additional medical or registration personnel may also be present in the room with the Dr. Brauer.
- I understand that my voice and image may be recorded in order to assist the medical or registration personnel and I consent to any such audio and video recording.
- I understand there are potential risks to this technology, including but not limited to interruptions, unauthorized access, technical difficulties, and call termination. I understand there are alternatives and limitations to this type of care. I understand that my health care provider or I can discontinue the telemedicine consultation/visit if it is felt that the video conferencing connections are not adequate for my situation.
- I understand that not all concerns/illness can be covered by telemedicine and in some instances, it will be recommended that I be seen in person at *Bluegrass Family Allergy* or referred to an ER or another specialist office. I am responsible for this followup care.

Financial Responsibility

- I understand that any copays or insurance deductible amounts will be collected at the time of service and cannot be refunded once the consultation/visit has begun.
- **I acknowledge that my telemedicine visit may not be covered by my insurance. I agree to pay any and all costs not covered by my insurance company.**

Authorizations

I hereby grant permission to all providers and ancillary staff at *Bluegrass Family Allergy* to engage in Telemedicine services as described above. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment. I may revoke my consent in writing at any time by contacting *Bluegrass Family Allergy*.

I have read the Telemedicine Consent and agree with all stated above.

Printed Patient Name _____ Date_____

Patient or Legal Guardian Signature _____