Deerwood Women's
HEALTH & WELLNESS

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Telemedicine services utilize interactive videoconferencing equipment which enables our providers to deliver health care services to patients remotely.

1. I understand that I will not be physically in the same room as my health care provider. If anyone else is present for the visit they will be announced and verbal consent obtained. (ex: nurse, student, etc.)

2. I understand that standard of care for my telemedicine visit will be the same as an in-person visit in the office, and that the laws that protect privacy and confidentiality of healthcare information apply to telemedicine services.

3. I understand that telemedicine visits are optional, and that I have the right to refuse or discontinue a visit at any time. This will be documented in the medical record, and will not affect future visits with the practice. To revoke my consent for telemedicine, please contact Deerwood Women's Health & Wellness at 254-420-0002.

4. I understand that connection interruptions may occur with videoconferencing equipment. If connection is not deemed adequate, alternative methods to complete the visit may need to be arranged.

5. I understand that my health care information may be shared with other individuals for scheduling and billing purposes, and that my insurance carrier will have access to medical records for quality review/audit.

6. I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit, and that health plan payment policies for telemedicine visits may be different from policies for in-person visits.

7. I acknowledge that this document will become a part of my medical record.

____ I attest that I have personally read this form, or had it explained to me and agree with its contents.

____ I attest that I am located in the state of Texas and will be in Texas during my telemedicine visit.

____ I attest that all of my questions have been answered and I am aware of the risks, benefits and alternatives to telemedicine visits.

______________________________	______________________________
Patient/Parent/Guardian Printed Name	Patient/Parent/Guardian Signature
______________________________	______________________________
Witness Signature	Date