Patient's Name:_____ DOB: _____

1. I understand that Advanced Specialty Care, PC, has recommended to me that I engage in a telehealth appointment with one or more of their health care providers.

2. Advanced Specialty Care, PC has explained to me how the telehealth technology will be used to connect me with a provider. Telehealth appointments may be conducted by videoconferencing, video images, still (high quality photo) images, or by telephone conference. I understand that this appointment will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.

3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telehealth appointment if it is felt that the videoconferencing connections are not adequate for the situation. I understand that I can discontinue the telehealth appointment at any time

4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the appointment other than my specialty health care provider in order to operate the equipment, or obtain medical information. All of our healthcare providers will maintain confidentiality of the information obtained. I further understand that I will be informed of their presence during the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telehealth examination room; and/or (3) terminate the telehealth appointment at any time.

5. I have been given an opportunity for an office visit, and in choosing to participate in a telehealth appointment, I understand that some parts of the examination will not be feasible via telehealth and this may impact healthcare decisions. After my telehealth visit if I wish an office visit it will be arranged to follow.

6. In an emergency situation, I understand that the responsibility of the telehealth specialist or provider may be to direct me to emergency medical services, such as emergency room. Or the telehealth provider may discuss with and advise my local provider. The telehealth specialist's or provider's responsibility will end upon the termination of the telehealth connection.

7. I understand that billing for the telehealth consultation will occur from Advanced Specialty Care, PC, and if covered by insurance will be processed accordingly. If the insurance deems this to be a non-covered service the standard fee of $175 for new patient or $95 for established patient will be your responsibility.

8. I have read this document carefully, and understand the risks and benefits of the telehealth appointment and have had my questions regarding the procedure explained and I hereby consent to participate in a telehealth appointment visit under the terms described herein.

_____ _____

Patient/Guardian signature Date and Time

**CONFIDENTIALITY STATEMENT:** The documents accompanying this transmission may contain confidential health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless required to do so by law or regulation and is required to destroy the information after its stated need has been fulfilled. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.