NOVA
Neurology Center

Telemedicine Consent Form

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

- I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
- I understand that I will not be physically in the same room as my health care provider. Others may also be present during the visit other than my health care provider in order to collect medical history and help operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the visit 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 telemedicine examination room: and or (3) terminate the consultation at any time.
- I understand that there are potential risks to using technology, including service interruptions, unauthorized access, and technical difficulties. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
- I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment. I may revoke my right at any time by contacting NOVA Neurology Center.
- I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
- I understand that I am responsible to ensure privacy and confidentiality during the telehealth visit and understand specific steps I can take to maintain privacy, such as conducting my visit in a private space. I understand that NOVA Neurology Center is not responsible for who may hear or see my health information at the place in which I choose to participate.
- I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
    - I understand that my insurance carrier will have access to my medical records for quality review/audit.
    - I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit.
    - I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.
    - I understand that telehealth may be non-covered or not considered reasonable or necessary by some insurers. I agree to pay for these services in full if not covered by insurance. Please call the office for self-pay rates.
- I understand that this document will become a part of my medical record.

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand; and (3) am located in the state of Virginia and will be in Virginia during my telemedicine visit(s)

Patient/Authorized Person’s Signature: ______________________________ Date: ______________