Valor Health

Consent to Receive Telemedicine Services

1. I understand that my health care provider wishes me to engage in a telemedicine consultation.
2. My health care provider has explained to me how the video conferencing technology will be used to affect such a consultation 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 telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Providers and staff involved in my care will maintain confidentiality of the information obtained.
5. I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a telemedicine consultation. I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the provider.
6. I understand that billing will occur from my practitioner.
7. I have had a direct conversation with my doctor, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

By engaging in the use of telehealth services, I certify:
☐ That I have read or had this form read and/or had this form explained to me
☐ That I fully understand its contents including the risks and benefits of the procedure(s).
☐ That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Patient Name: _____

Date: _____