Member Name: _____Date of Birth: ___ /___/__ Medical Record #_____

Member Location: _____Home Address: _____

Physician Name: _____ Location: _____
Consultant/ Therapist Name: _____ Location: _____
Consultant/ Therapist Name: _____ Location: _____

Informed Member Consent Form Telehealth Services

Telehealth, virtual check-ins, and/ or E-visits is the delivery of healthcare services using technology when the healthcare provider and member are not in the same physical location. Providers may include primary care practitioners, specialists, and/or subspecialists.

Electronically transmitted information may be used for diagnosis, treatment, follow-up, and/or member education, and may include any of the following:

• Medical records;

• Medical images;

• Interactive audio, video, and/or data communications; and/or

• Output data from medical devices, sound and video files.

Zoom Healthcare has interactive electronic systems used within its network. Security software and protocols are employed to protect the confidentiality of member information and imaging data. Safeguard measures include protecting against intentional or unintentional corruption.

Potential Member Benefits:

1. Improving access to specialized medical care by enabling members to either remain within physician's office or electronically discuss with physician on duty any test results and any consults with a distant specialist at a remote location.

2. Obtaining the expertise of a distant specialist.

Potential Member Risks: As with any medical procedure, there may be potential risks associated with the use of telehealth. These risks include, but may not be limited to:

1. Information transmitted may not be sufficient (e.g., poor resolution of images) to allow for appropriate medical decision making by physician on duty and a distant specialist.

2. Distant specialist may not be able to provide medical treatment using telehealth equipment nor provide for or arrange for any emergency care that may be required.

3. Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment.

4. Security protocols could fail, causing a breach of privacy of confidential medical information.

5. A lack of access to complete medical records may result in errors.

Informed Consent for Telehealth

By signing this form, the Member/ Patient understands and agrees to the following:

1. The laws that protect the privacy and confidentiality of medical information also apply to telehealth (telemedicine/e-visits/virtual visits). Information obtained during a telehealth encounter, which identifies member, should not be disclosed to any third party without members consent except for the purposes of treatment, payment, and healthcare operations.

2. Telehealth may involve electronic communication of member confidential medical information to other medical providers who may be located in other areas, including out-of-state.

3. Member understand that other individuals' other than physician on duty and the distant specialist may also be present and have access to members medical information during the consultation in order to operate the video equipment, should such equipment be utilized.

4. Member understands that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the distant specialist.

5. In an emergency consultation, member understand that the responsibility of the distant specialist is to advise physician on duty and that the responsibility of the distant specialist will conclude upon the termination of the video conference connection.

6. Member has the right to withhold or withdraw consent to the use of telehealth during the course of member care at any time. Member understands by withdrawing consent will not affect any future care or treatment, nor will it subject member to the risk of loss or withdrawal of any health benefits to which the member is entitled.

7. Member has the right to inspect all information obtained and recorded during the course of a telehealth interaction, and may receive copies of this information for a reasonable fee. Such inspection and copying of records shall be subject to physician on duty or distant specialist's office policies and procedures.

8. Member may expect the anticipated benefits from the use of telehealth in members care, but that no results can be guaranteed. The members condition may not be cured or improved, and in some cases, may get worse.

9. Member understands that the members condition may require a referral to a specialist for further evaluation and treatment.

10. A variety of alternative methods of medical care may be available to member, and the member may choose one or more of these at any time.

The physical and/ or occupational therapist(s) on duty has explained the alternative care methods to the members satisfaction.

The member has read and understand the information provided above regarding telehealth, have discussed it with the physician on duty and all questions have been answered to members satisfaction.

The member hereby gives their informed consent for the use of telehealth in their medical care.

I hereby consent to and authorize _____ (name of physician on duty) to use telehealth in the course of my diagnosis and treatment.

Signature of Member (or person authorized to sign for Member): _____

Date: If authorized signer, relationship to Member: Witness: _____

Date: Signature of Therapist on duty_____ Date: __ /__/__

I have been offered a copy of this consent form (member's initials) _____