COMPREHENSIVE
PAIN SPECIALISTS

# TELEMEDICINE INFORMED CONSENT

Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable Healthcare 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.
- I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
    - If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my Healthcare 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 Comprehensive Pain Specialists at 303-469-3182.
- I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
- 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 this document will become a part of my medical record.

**This authorization expires 12 months from the date signed.**

**By signing this I acknowledge that I have been notified and have read and understand telemedicine services and I give my consent to telemedicine appointments.**

_____ _____

**Signature of Patient or Personal Representative** **Relationship to Patient**

_____ _____

**Printed Name of Patient or Personal Representative** **Date**