Informed Consent to Telemedicine Consultation

I have been asked by my healthcare provider to take part in a telemedicine consultation with **LIFE CHOICES MEDICAL CLINIC dba THE SOURCE**, its Medical Providers, Counselors, HHSC Navigators, associates, technical assistants, and others deemed necessary to assist in my medical care through a telemedicine consultation.

I understand the following:

1. The purpose is to assess and treat my medical / other condition, obtain counseling, apply for Texas Benefits, or receive results of testing I have obtained.

2. The telemedicine consult is done through a two-way video link-up whereby the Medical Provider or other health provider at **The Source** can see my image on the screen and hear my voice. However, unlike a traditional medical consult, the provider/counselor or other health provider does not have the use of the other senses such as touch or smell; and it may not be equal to a face-to-face visit.

3. Since the telemedicine consultants practice in a different location and do not have the opportunity to meet with me face-to-face, they must rely on information provided by me or my onsite healthcare providers. **The Source** and affiliated telemedicine consultants cannot be responsible for advice, recommendations and/or decisions based on incomplete or inaccurate information provided by me or others.

4. I can ask questions and seek clarification of the procedures and telemedicine technology.

5. I can ask that the telemedicine exam and/or videoconference be stopped at any time.

6. I know there are potential risks with the use of this new technology. These include but are not limited to:

- Interruption or disconnection of the audio/video link.
- A picture that is not clear enough to meet the needs of the consultation.
- Electronic tampering. If any of these risks occur, the procedure might need to be stopped.

7. The consultation notes may only be viewed by medical and non-medical persons for evaluation, informational, educational, quality, or technical purposes on a need to know basis.

8. I will not receive any royalties or other compensation for taking part in this telemedicine consult or associated with any use by **The Source**.

9. I understand I can make a complaint of my provider to the Texas Medical Board by going online at http://www.tmb.state.tx.us/page/place-a-complaint or calling the Complaint Hotline at 800-201-9353.

10. If this appointment is to assist in application for Health and Human Services Commission (HHSC) Benefits, I understand **The Source** is helping me to apply for benefit via the HHSC

Benefits Website. I acknowledge that **The Source** is acting on my behalf and not on the behalf of HHSC. I know that I DO NOT have to sign this form to apply for, get services or be approved for HHSC benefits.

11. If applying for HHSC benefits, I authorize HHSC to share facts about my case with **The Source,** which may include private facts about my health.

I, the undersigned patient, do hereby understand and state that I agree to the above consents. If I do not agree to any consents, I drawn a line through those items.

I certify that this form has been fully explained to me. I have read it or have had it read to me. I understand and agree to its contents. I volunteer to participate in the telemedicine examination. I authorize **The Source** and the Nurse Practitioners, Counselors, nurses, and other providers involved to perform procedures that may be necessary for my current medical condition.

Date: _____ Form Expiration (one year if not specified): _____

Witness: _____ Interpreter (if applicable):_____

HHSC APPLICANTS ONLY:

I confirm one of the following: (Initial one)

____ I am only sharing my personal information to complete my application or make changes to my benefits case.

____ Share my whole case record.

____ Share only the following listed facts about my case record: _____

If you are signing as a legally authorized representative (defined as those persons listed below) of the person participating in the telemedicine consultation, check the phrase that best describes your authority to act for the person. Proof of this relationship may be requested.

____ A parent or legal guardian if the person is a minor.
____ A legal guardian if a judge has ruled the person is not competent to manage their own personal affairs.
____ An agent named as the person's Durable Power of Attorney for Healthcare
____ The person's court-appointed attorney ad litem
____ The person's court-appointed guardian ad litem
____ A personal representative or statutory beneficiary if the person is deceased.
____ An attorney retained by the person or by another person on this form.
____ If the person Is deceased, their personal representative must be the executor, independent executor, administrator, independent administrator or temporary administrator of the estate.