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**, 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 **Life Choices Medical Clinic** 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. **Life Choices Medical Clinic** 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 **Life Choices Medical Clinic**.

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 **Life Choices Medical Clinic** is helping me to apply for benefit via

the HHSC Benefits Website. I acknowledge that **Life Choices Medical Clinic** 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 **Life Choices Medical Clinic,** 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 **Life Choices Medical Clinic** and the Nurse Practitioners, Counselors, nurses, and other providers involved to perform procedures that may be necessary for my current medical condition.

Date: _____ Signature: _____

Interpreter (if applicable):_____ Form Expiration (one year if not specified): _____