AUTHORIZATION AND CONSENT/REFUSAL FORM FOR TELEMEDICINE | Christopher Tran MD | Bay Area ENT Specialists

Patient name:_____Date of Birth:_____Date of Appointment:_____

I understand that telemedicine is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to Bay Area ENT Specialists providing health care services to me via telemedicine.

I understand that the laws that protect privacy and confidentiality of medical information also apply to telemedicine. Reasonable and appropriate efforts have been made to eliminate confidentiality risks. As always, your insurance carrier will have access to your medical record for quality review/audit. I agree that any dispute arriving from the telemedicine service will be resolved in Texas, and that Texas law shall apply to all disputes.

I understand that I will be responsible for any copayments or coinsurances that apply to my telemedicine visit. I authorize for a credit card payment to be securely stored and payment in full deducted when a telemedicine visit has occurred.

I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care of treatment. I may revoke my consent orally or in writing at any time by contacting Bay Area ENT Specialist. As long as this consent is in force (has not been revoked) Bay Area ENT Specialists may provide healthcare services to me via telemedicine without the need for me to sign another consent.

In order to qualify for telemedicine, I understand that I must have a face-to-face visit within the preceding 12 months if determined appropriate by my provider. I understand that I may expect the anticipated benefits form the use of telemedicine in my care, but that no results can be **guaranteed or assured.**

****** Computer or Cell phone must have audio and visual capability******

I have read and understood the information provided above regarding telemedicine, and all of my questions have been answered to my satisfaction. I hereby give my consent for the use of telemedicine in my medical care.

_____ _____

Print Name (note if Parent or Guardian) **Signature**

_____ _____

Witness **Date/ Time**

☐ I **DO NOT** wish to participate in the telemedicine service as described above.

_____ _____

Signature **Date/Time**

_____ _____

Witness **Date/ Time**