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NORTH TEXAS ALLERGY & ASTHMA CENTER

DENTON SOUTH
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Telemedicine Consent:

1. **Introduction**: Telemedicine involves the real-time evaluation, diagnosis, consultation on, and treatment of a health condition using advanced telecommunications technology, which may include the use of interactive audio, video, or other electronic media. As such, telemedicine allows the provider to see and communicate with the patient in real time.

2. **Consent for Treatment**: I voluntarily request North Texas Allergy & Asthma Center physician(s) and such associates, technical assistants, and other health care providers as they may deem necessary ("North Texas Allergy & Asthma Center Telemedicine Providers") to participate in my medical care through the use of telemedicine.

I understand that North Texas Allergy & Asthma Center Telemedicine Providers (i) may practice in a different location than where I present for medical care, (ii) may not have the opportunity to perform an in-person physical examination, and (iii) rely on information provided by me. I acknowledge that North Texas Allergy & Asthma Center Telemedicine Providers' advice, recommendation, and/or decision may be based on factors not within their control, such as incomplete or inaccurate data provided by me or distortions of diagnostic images or specimens that may result from electronic transmissions. I acknowledge that it is my responsibility to provide information about my medical history, condition and care that is complete and accurate to the best of my ability. I understand that the practice of medicine is not an exact science and that no warranties or guarantees are made to me as to result or cure.

I understand that I will not be physically in the same room as my health care provider. I will be notified of, and my consent obtained for anyone other than my health care provider present in the room. 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 the medical record. I also understand that my refusal will not affect my right to future care or treatment. 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, coinsurances, or deductibles that apply to my telemedicine visit. I understand that health insurance plan payment policies for telemedicine visits may be different from policies for in-person visits.

I consent to having my health care plans and general instructions regarding my health sent to me by email and/or conventional mail.

If North Texas Allergy & Asthma Center Providers determine that the telemedicine services do not adequately address my medical needs, they may require an in-person medical evaluation. In the event the telemedicine session is interrupted due to a technological problem or equipment failure, alternative means of communication may be implemented, or an in-person medical evaluation may be necessary. If I experience an urgent matter, such as a bad reaction to any treatment after a telemedicine session, I should alert my physician and, in the case of emergencies, dial 911, or go to the nearest hospital emergency department.

3. **Release of Information**: To facilitate the provision of care and/or treatment through telemedicine, I voluntarily request and authorize the disclosure of all and any part of my medical record (including oral information) to North Texas Allergy & Asthma Center Telemedicine Providers. I understand and agree that the information I am authorizing to be released may include: 1) AIDS/HIV test results, diagnosis, treatment, and related information; 2) drug screen results, information about drug and alcohol use and treatment; 3) mental health information; and 4) genetic information.

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I understand that the disclosure of my medical information to North Texas Allergy & Asthma Center Telemedicine Providers, including audio and/or video, will be by electronic transmission. Although precautions are taken to protect the confidentiality of this information by preventing unauthorized review, I understand that electronic transmission of data, video images, and audio is new and developing technology and that confidentiality may be compromised by failures of security safeguards or illegal and improper tampering.

I certify that this form has been fully explained to me, that I have read it or have had it read to me, and that I understand its contents. I certify that I am located in the state of Texas and will be in Texas during my telemedicine visit(s).

I, the patient or patient's representative and the North Texas Allergy & Asthma Center Telemedicine Providers rendering or providing medical care, health care, or safety or professional or administrative services directly related to health care to patient agree: (1): that all health care rendered shall be governed exclusively and only by Texas law and in no event shall the law of any other state apply to any health care rendered to the patient; and (2) in the event of a dispute, any lawsuit, action, or cause of which in any way relates to health care provided to the patient shall only be brought in a Texas court in the county/district where all or substantially all of the health care was provided or rendered (not received) and in no event will any lawsuit, action, or cause of action ever be brought in any other state. The choice of law and forum selection provisions of this paragraph are mandatory and are not permissive.
This telemedicine, email and mail consent will remain in effect as long as telemedicine services are offered by North Texas Allergy & Asthma Center and applies to new patient and all follow-up visits going forward.

_____ _____

My signature below indicates I understand and agree to pay in full any balance unpaid by my insurance provider.

Patient's Printed Name: _____

Patient's Signature: _____ Date: _____

Legal Representative's Printed Name:_____

Legal Representative's Signature:

_____

Date: _____

If representative, specify relationship: _____

Patient Complaint Procedure: While we hope that every patient's visit goes smoothly, it is important that we are notified of patient concerns so that we can address them. If you have comments, questions, or concerns, we recommend that you or your representative discuss them with your immediate caregiver or speak to the office manager. Complaints about physicians, as well as other licenses and registrants of Texas Medical Board, including physician assistants, acupuncturists, and surgical assistants may be reported for investigation at the following address: Texas Medical Board Attention Investigations 333 Guadalupe, Tower 3, Suite 610 PO Box 2018, MC-263 Austin, TX 78768-2018. Assistance in filing a complaint is available by calling the following telephone number: 1- 800-201-9353. For more information, visit the Texas Medical Board website at www.tmb.states.tx.us