



## TELEHEALTH CONSENT TO TREATMENT

**PURPOSE:** This form obtains your consent to participate in a telemedicine consultation, also known as “Telehealth” services. Telehealth is the delivery of health care services using two-way video communications and/or the electronic exchange of information. Since this is different than in-person health care services you may typically receive, it is important for you to understand and be aware of and comfortable with the benefits and possible risks. For your Telehealth visit, a Washington University or BJC Medical Group provider will communicate using electronic and video transmissions and will have access to your medical records while you are being treated at home. This will enable your provider to determine an appropriate treatment plan for your condition. Participating in this Telehealth program will give you access to your provider without having to travel to your provider’s office, for inpatient/outpatient care.

Some possible risks associated with the use of Telehealth services include, but may not be limited to:

- Instances in which the electronic information may not be sufficient for appropriate medical decision making by the provider.
- Equipment issues, which could cause delays in your medical evaluation and treatment.
- Although rare, security measures could fail, possibly exposing your privacy and your personal medical information.
- Finally, in some cases, Telehealth services may not be as complete as in-person services, and if your provider believes an in-person visit is necessary, he or she may recommend that you schedule an in-person visit.

It is important that you understand and agree to the following statements:

1. I understand that engaging in a telemedicine visit with my health care provider at Washington University/BJC Medical Group is optional. I have the right to discontinue this service at any time. I further understand that in place of telehealth services, I may request a face-to-face visit with my health care provider.
2. I have been informed and understand the alternatives to the Telehealth services that are available to me, and give my consent to proceed with Telehealth services.
3. I understand that my provider will be at a different location from me. I understand that a telemedicine visit will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as the consulting health care provider and the provider will not be able to physically examine me.
4. I understand that the video portion of the telehealth service will not be recorded.
5. I understand that others may also be present during the visit other than my health care provider and consulting health care provider(s) in order to operate the video equipment and/or facilitate the Telehealth consultation. I further understand that I will be informed of their presence in the visit and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask other personnel to leave the telemedicine examination room; and/or (3) end the visit at any time.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date of Service: \_\_\_\_\_

6. I understand that I have the right to request a copy of this informed consent and upon request it will be provided to me.
7. I understand there is a possible risk of an incomplete or ineffective visit due to technological issues, and that if any of the technological issues occur, the visit may end. The technological issues include but are not limited to: a) failure, interruption or disconnection of the audio/video connection; b) a picture that is not clear enough to meet the needs of the visit; and/or c) a minor risk of access to the visit through the interactive connection by electronic tampering.
8. I understand that my provider or I can stop the telemedicine visit if the telehealth connections are not adequate for the situation.

**ACKNOWLEDGEMENT & CONSENT:** I have read and understand this consent. I have been given an opportunity to ask questions and all of my questions have been answered to my satisfaction. The risks, benefits, and alternatives of the Telehealth visit have been explained to me and I hereby consent to participate in Telehealth services as described in this document during this course of treatment.

\_\_\_\_\_

\_\_\_\_\_

Signature of Patient or Person Authorized to Consent      Date

Relationship to Patient

**ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITIES:**

I agree the information I gave to apply for payment is correct for any third-party payers, including Medicare or Medicaid. I have been given a paper listing my rights as a Medicare or Medicaid patient. I know I can ask for a review of my record to find out about any payments or charges I may owe if Medicare or Medicaid will not cover my charges.

If I receive Medicare, Medicaid or other insurance benefits, I know I am responsible to know what my insurance covers and that I can call my insurance plan if I have questions. I also understand I am responsible for any deductibles, co-insurance, and any non-covered charges. I know that I may receive separate bills for services provided by healthcare workers who are not employed by Washington University or BJC Medical Group – like a bill for laboratory testing or imaging services requested by my doctor.

I authorize direct payment to Washington University or BJC Medical Group of all insurance benefits and I authorize release of my personal health information as may be required for my insurance plan to pay such benefits. I understand that I am responsible, subject to Washington University's or BJC's Financial Assistance Policy, for portions of my bill not covered by insurance and I understand I will be held solely financially responsible if:

- All conditions and guidelines set forth by my insurance carrier are not met
- I fail to give valid insurance information within the filing guidelines set by my insurance plan
- I receive services not covered by my insurance plan
- I am covered by a plan BJC Medical Group doctors are not contracted with
- I do not have insurance

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date of Service: \_\_\_\_\_

I also agree that I have received or have access to signs and/or brochures which contain information about:

- Advance Directives
- Privacy of my health care information and who may have access to my information
- Office Hours and Office Policies
- What Rights and Responsibilities I/we have as a patient or family member and who to contact if I have questions

I have read this whole form, or had it read and explained to me, and I had the opportunity to ask questions.

\_\_\_\_\_  
Signature of Patient or Person Authorized to Consent      Date      Relationship to Patient

\_\_\_\_\_  
Signature of Guarantor if different than above

**RECEIPT OF NOTICE OF PRIVACY PRACTICES:**

I acknowledge I have received or I have been provided the opportunity to receive a copy of Washington University's or BJC's Notice of Privacy Practices that explains when, where, and why my protected health information maybe used or shared by Washington University or BJC Medical Group.

<https://www.bjc.org/for-patients-visitors/patient-privacy>

<https://wuphysicians.wustl.edu/for-patients/for-your-protection/notice-of-patient-privacy-practice-hipaa>

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Signature of Patient or Person Authorized to Consent      Date      Relationship to Patient