



Virtual Dermatology / Telederm Visits Informed Consent

Patient Full Name: _____ **DOB:** ____/____/____

If under age 18, name of Parent or Legal Guardian:* _____

Purpose: The purpose of virtual visits is to enable patients to get medical or cosmetic care by providers without traveling to the practice.

During the Virtual Dermatology Visit:

1. We will use a HIPAA compliant platform for our visit.
2. Details of your medical history, prior tests and examinations will be discussed, as well as a current history and plan through the use of interactive audio and video technology.
3. Physical examination of you will be visual, where feasible.
4. Digital photos may be taken to enter into your chart during the virtual dermatology visit, but we will not record video or audio with our HIPPA compliant system.

Medical Information and Records: All existing laws regarding your access to medical information and copies of your medical records apply to this virtual dermatology visit.

Confidentiality: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the virtual dermatology visit. All existing confidentiality protections under federal and Arizona State law apply to information disclosed during this telemedicine consultation.

Risks and Consequences: The virtual dermatology visit will be similar to a routine medical office visit, except interactive video technology will allow you to communicate with a provider at a distance. At first you may find it difficult or uncomfortable to communicate using video. The use of video technology to deliver healthcare and educational services is a new technology and may not be equivalent to direct patient to provider contact. Following the virtual dermatology visit, your provider may recommend a visit be scheduled in the future for further evaluation, for a procedure, or follow-up. **If you feel that a virtual dermatology visit will not allow a provider to effectively see or diagnose your condition, please let us know and we will reschedule your appointment at our clinic as soon as possible.**

Rights: You may withhold or withdraw consent to the virtual dermatology visit (i.e. end the appointment) at any time without affecting your right of future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled. You have the option to consult with the provider in-person if you schedule an appointment during regular business hours.

Financial Agreement: Billing for virtual dermatology visits will be similar to the regular office visit fee. If you elect to go through insurance, we will submit claims to them on your behalf but do not guarantee coverage or payment. Similar to regular office visits, if you have a deductible, you will likely receive a bill for your visit. If your insurance company does not currently participate with virtual medical appointments, if you do not participate with medical insurance, or if you have a high deductible and would prefer to pay out-of-pocket, we ask that you pay a \$100 cash fee for your visit, which will be charged to your credit card at the initiation of your virtual visit, and within one week we will provide you with a claim form that you may submit to your insurance company for possible reimbursement should their guidelines change. In the event this visit is not covered by your insurance, the fee incurred will be owed by the patient/patient's responsible party.

Signed Consent:

I have been advised of all the potential risks, consequences and benefits of virtual dermatology visits. I have asked the practice representative any questions that I have about the written information provided above. I understand the written information provided above.

Patient or Parent/Legal Guardian Signature: _____ Date: _____

This consent is in effect until cancelled by the patient or person authorized to consent for the patient. 03/2020