neurocare Centers of America

Long Island Neurocare Therapy

Phone: 631-714-4100

Telemedicine Consent

Patient Name: _____ DOB: _____

Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

1. I understand that the same standard of care applies to a telemedicine visit as applies to an in- person visit.
2. 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 healthcare provider present in the room.
3. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
    a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
4. 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 my medical record. I also understand that my refusal will not affect my right to future care or treatment.
    a. I may revoke my right at any time by contacting Long Island Neurocare Therapy at 631-714-4100.
5. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
6. I understand that certain procedures such as a physical exam, allergy testing, pulmonary function tests, etc., cannot be performed via telemedicine.
7. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
    a. I understand that my insurance carrier will have access to my medical records for quality review/audit.
    b. I understand that I will be responsible for any out-of-pocket costs

such as copayments or coinsurances that apply to my telemedicine visit.

c. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.
d. I understand that I may be billed a flat fee of $50.00 for this visit if it is not covered by my insurance.

8. I understand that this document will become a part of my medical record.

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand; and (3) am located in the state of New York and will be in New York during my telemedicine visit(s).

_____ _____

Patient's/parent/guardian signature Date

_____ _____

Witness signature Date