THE CECIL SPECIALTY CLINIC

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Telemedicine Consent

In order to give patients the greatest availability in our telehealth services the patient is given the option to be seen via our telehealth programs based in our satellite offices. We have locations throughout the state in Campbellsville, Russell Springs, Louisville and Monticello. Our providers work at all of these locations and it would not impact the continuity of care. The patient may see one of our partner hospitals listed on their billing statement. Our partner hospitals accept a wide range of insurances (in some cases--they are able to accept more plans than we can in our main office). Consenting to telehealth services includes consenting to be seen through our satellite offices. Patients are always allowed to physically come into our Louisville office to be seen. Consent for telehealth is not a requirement of receiving care from us, but dates will be limited based on the provider's location and availability. This has been discussed with the patient and the patient has orally confirmed understanding and requested participation in our telehealth program as described above.

Telemedicine services is the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telemedicine also involves the communication of my medical/mental information, both orally and visually, to health care practitioners. I understand that my health care providers have offered me the opportunity to utilize telemedicine services as part of my treatment at the Hepatitis C Treatment Center "HCTC." I voluntarily authorize HCTC and its physicians, practice professionals, and other persons (such as colleagues, physicians-in-training, technical assistants, and other health care providers) to utilize telemedicine as part of my treatment. I agree to participate in a telemedicine evaluation/supervision. By signing this agreement, I authorize the electronic transmission of my medical information and/or videoconference session so that it can be viewed by a doctor and other persons involved in my medical or mental health care. I understand that as with any technology, telemedicine does have its limitations. There is no guarantee, therefore, that this telemedicine session will eliminate the need for me to see a specialist in person.

I understand there are potential risks with this technology: (1) The video connection may not work or that it may stop working during the consultation. (2) The video picture or information transmitted may not be clear enough to be useful for the consultation. (3) I may be required to go to the location of the consulting physician if it is felt that the information obtained via telemedicine was not sufficient to make a diagnosis. I give my consent to be interviewed by the consulting health care provider. I also understand other individuals may be present to operate the video equipment and that they will take reasonable steps to maintain confidentiality of the information obtained.

Information gathered from me as part of the telemedicine services may be used for diagnosis, therapy, follow-ups and/or education, and may include, without limitation, the following: (1) medical records

(2) medical images (3) live two-way audio and video (4) output data from medical devices and sound/video files (5) electronic communication. I agree that the use of telemedicine services has been explained to me, including purpose, limitations, benefits, anticipated duration, reasonable alternatives, the option to opt out of telemedicine, and the risks of opting out. I understand the following: (1) I have the right to withhold or withdraw my consent to telemedicine without affecting my right to future care/treatment. (2) I have the right to inspect all information obtained and recorded in the course of telemedicine services and may receive copies of this information for a reasonable fee. (3) A variety of alternative methods of medical care may be available to me, and that I may choose one or more of the options of care. (4) Telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state. (5) It is my duty to inform my providers of electronic interactions regarding my care that I may have with other providers. (6) My provider and I may discontinue the telemedicine services if it is felt that the videoconferencing is no longer adequate for care. (7) In an emergent consultation, my provider may refer me to my local practitioner and that my provider's responsibility will conclude upon the termination of the remote connection. I authorize the release of any relevant medical information about me to the consulting health care provider, any staff the consulting health care provider supervises, third party payers and other healthcare providers who may need this information for continuing care purposes. Upon completion of virtual services, I authorize HCTC, LLC representatives, to sign on behalf of the responsible adult where a responsible adult/parent/caregiver signature is required for insurance or other payor documentation.

I hereby release HCTC, LLC, its personnel and any other person participating in my care from any and all liability which may arise from the taking and authorized use of such videotapes, digital recording films and photographs.

I have read this document and understand the risk and benefits of the telemedicine consultation and have had my questions regarding the procedure explained and I hereby consent to participate in a telemedicine visit under the conditions described in this document.

I consent to telemedicine services

_____ _____

Signature Date

I **DO NOT** consent to telemedicine services.

_____ _____

Signature Date

Printed Name: _____