VMP, llc
Expanding Genetic Horizons

Voice: 404.793.7800
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Telehealth Consent Form

2104

VMP (Virtual Medical Practice, LLC) Telehealth involves the use of electronic communications to enable health care providers to provide patient care through the means of live two-way audio and/or video. The purpose of this form is to obtain your consent to participate in a Telehealth consultation for various medical conditions/illnesses. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following: Patient medical records, Medical images, Live two-way audio and/or video and Output data from medical devices and sound and video files.

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and ensure its integrity against intentional or unintentional corruption. Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the Telehealth consultation.

Per the HIPAA Omnibus Rule, VMP uses e-mail, voice, & fax systems which are HIPAA compliant but there may be a lack of security on your end, especially if you are using VoIP telephone service, wireless phone providers or a Gmail, Yahoo! Mail, Hotmail (or similar) account. By your signature on this form you acknowledge the HIPAA security risks of the systems YOU use for email, voice, or fax and you still provide VMP the authority to send your private information to these potentially unsecure services used by YOU.

Nature of the Telehealth Consent

During the Telehealth consultation: Details of your medical history, examinations and tests will be discussed using interactive video and/or audio, a virtual examination may take place, other medical professionals such as Medical Assistants and/or Scribes may be present during the visit to assist the provider, and photographs may be taken of you during the service. The Telehealth providers responsibility will end upon the termination of the Telehealth connection.

Possible Risks

As with any medical procedure, there are potential risks associated with the use of Telehealth. These risks include, but may not be limited to: In rare cases, information transmitted may not be sufficient (e.g., poor resolution of images) to allow for appropriate medical decision making by the provider. There are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. The session may be discontinued by the patient and/or the provider if the video conference connection is not adequate for the situation.

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Your Rights

You may withhold or withdraw consent to the Telehealth consultation at any time without affecting your right to future care or treatment or risking the loss or withdraw of any program benefits to which you would otherwise be entitled.

_____Initial

Virtual Medical Practice, llc
Clinic: 1875 Old Alabama Rd, Suite 220, Roswell, GA 30076
Mail to: 5579 Chamblee Dunwoody Rd, Suite 110, Atlanta, GA 30338

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Billing and Payment

Payment in full for the appointment is expected before the appointment. VMP is not in network and is not contracted with any insurance plan or company. VMP will provide you a claim form (depending if your insurance allows) that you may file directly with your insurance. It is also your responsibility to provide accurate insurance information prior to the service. Telehealth services may or may not be covered by your insurance plans.

I have read the contents of the 2 pages of this Telehealth Consent, and I fully understand and accept all terms by signing below. My consent to the above and any or all associated assignments remains effective until I revoke it in writing.

Please sign and date on the lines below and return to our office by mail/email/fax prior to your appointment.

_____ _____

PLEASE PRINT - PATIENT NAME **DATE OF BIRTH**

_____

PLEASE PRINT –NAME OF PARENT/GUARDIAN OF PATIENT AND THE RELATIONSHIP TO PATIENT if so signing

_____ _____

SIGNATURE – PATIENT OR PARENT/GUARDIAN **DATE SIGNED**

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