Burrows Family Practice, Inc.

Telehealth Consent Form

1. My health care provider wishes me to engage in a telehealth consultation and has explained to me how the video conferencing technology will be used to affect such a consultation and that it 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 my health care provider.
2. I have met the following criteria for a telehealth consultation:
   a. I have an Apple device with Facetime for the consultation
      OR
   b. I have access to Skype, Dr. Burrows user name: olivercornhusker
   c. I am Not a Medicare patient
3. I understand there are potential risk to this technology, including interruptions, unauthorized access and technical difficulties. I further understand that my healthcare information may be shared with other individuals for scheduling, billing purposes and video operation, and that I will be informed of their presence. I have the right to request the following: 1) omit specific details of my medical history/physical examination 2) ask non-medical personnel to leave the telehealth exam room and or 3) terminate the consultation at any time.
4. I understand that billing will occur from my practitioner for this telehealth visit. Co-payments will be due and payable before the telehealth consultation. Payments may be made on the www.**BurrowsFamilyPractice.org** website.

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Print Patient First and Last Name | Date of Birth

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Patients Signature | Date