EPIC WELLNESS
Workplace Health Solutions

# TELEMEDICINE INFORMED CONSENT

**Patient Name**: _____ **Date of Birth**: _____

**Provider Name:** Dr. Wendy Mehaffey, D.C.
**Provider Location**: Epic Wellness, 20 Kimball Ave, Suite 201A, South Burlington, VT 05403

I understand, in order to receive Telemedicine services from Epic Wellness, I must be located in the state of Vermont. By signing this form, I confirm my location is within the state of Vermont.

Telemedicine involves the use of audio, video or other electronic communications by a health care provider to interact with you and review your medical information for the purpose of diagnosis, therapy, follow-up and/or education. During your telemedicine consultation, details of your medical history and personal health information may be discussed with you through the use of interactive video, audio, transmission of medical information and images, or other telecommunications technology. Additionally, a physical examination of you may take place.

By Signing this Form, I Understand the Following:

1. All services the provider delivers to me through telemedicine will be delivered over a secure connection that encrypts data and data files that comply with the requirements of the Health Insurance Portability and Accountability Act (HIPAA) of 1966, public law 104-191.
2. All existing confidentiality protections under federal and state law apply to information used or disclosed during my telehealth consultations/visit.
3. I understand that the provider determines whether or not the conditions being diagnosed and/or treated are appropriate for a telehealth encounter.
4. I understand that I will be informed of the presence of any individual who will be participating in or observing my consultation with the provider at the distant site and that I will be asked for my permission for that participation or observation.
5. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time without affecting my right to future care or treatment.
6. I understand that I may receive a bill from the provider for telemedicine consultations/visits.
7. I understand that neither the treating provider nor I will create an audio/video recording of any of our telemedicine encounters.
8. I understand that while I may benefit from telemedicine, results cannot be guaranteed or assured.
9. I understand that this consent may apply to more than one telemedicine encounter as part of my ongoing treatment.

**Patient Consent to the Use of Telemedicine:**
I have read and understand the information provided above regarding telemedicine, have had the opportunity to ask questions about this information, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care and authorize the transmission of any relevant medical information to providers and their staff involved in my medical or mental health care.

_____ **Date**: _____
**Signature of Patient (or person authorized to sign for patient)**