PETER CHRISTENSEN HEALTH CENTER
129 OLD ABE ROAD
LAC DU FLAMBEAU, WI 54538-9386
(715) 588-3371 FAX (715) 588-2039

INFORMED CONSENT TO PARTICIPATE IN TELEMEDICINE SERVICES

I, ____________________________________, have been asked to receive medical services via Telemedicine/telehealth. I understand that I will be receiving health care services through interactive videoconferencing/phone equipment. The Telemedicine/telehealth Provider has explained to me how the videoconferencing/phone technology will be used to provide such services to me. I understand that my Telemedicine/telehealth sessions 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.

I understand that my participation in Telemedicine/telehealth is voluntary, and that I have the right to refuse to take part, limit, or to stop taking part in Telemedicine/telehealth interactions at any time without affecting my care, now or in the future, at Peter Christensen Health Center. I further understand that I do not have to take part in Telemedicine/telehealth to be treated at Peter Christensen Health Center.

The benefits of Telemedicine/telehealth have been explained to me, including but not limited to the following:

- Reduced travel for healthcare
- Increased convenience
- Focused healthcare information
- Improved access to healthcare services and providers
- Access to a medical provider during a state of emergency

I have also been advised that there are potential risks to this technology. These risks may include but not limited to the following:

- The audio/video connection may fail to work or may be interrupted or become disconnected during the appointment;
- The interactive connection may not provide a picture that is clear enough to meet the needs of the appointment;
- There is a small chance that someone could access the consultation through the interactive connection by electronic tampering.

I understand that, the health care providers will have access to any relevant health information about me including any/all medical records at Peter Christensen Health Center. In this situation, both are off-site.

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I understand that my personal information will be held in strict confidence, and shared only on a need-to-know basis, and even then only the minimum information necessary will be disclosed.

I understand that there will be a confidential electronic health record of my Telemedicine/telehealth sessions(s) maintained by Peter Christensen Health Center, and that I have the right to inspect all recorded documentation during a Telemedicine/telehealth session or consultation, and may receive copies of this documentation.

I understand that there may be follow-up Telemedicine/telehealth sessions, but if at any time during my Telemedicine/telehealth sessions I do not wish to participate, I have the right to refuse to take part in Telemedicine/telehealth interactions.

I understand that there will be no photographs, video recording and/or audio recording taken during my Telemedicine/telehealth session or consultation by my provider or Peter Christensen Health Center.

I understand that I must give my informed consent to participate in Telemedicine/telehealth and receive Telemedicine/telehealth services. I further understand that I will not receive any royalties or other compensation for taking part in Telemedicine/telehealth sessions.

I understand that, if my condition is a medical emergency the responsibility of the Telemedicine/telehealth provider will be to contact emergency personnel for my health and wellbeing at their discretion.

I understand that there will be no physical exam by my provider performed during a Telemedicine/telehealth appointment.

I understand that, I and/or my insurance will be billed by Peter Christensen Health Center for my Telemedicine/telehealth appointment just as if I was being seen in person by a provider of Peter Christensen Health Center.

I understand that, it is my responsibility to ensure I am in a private place where others cannot hear the conversation regarding my medical information between me and the Telemedicine/telehealth provider.

I certify that this form and the purposes and processes of Telemedicine/telehealth services have been fully explained to me and I have read and understand this form or have had it read to me. I

understand the risks and benefits of Telemedicine/telehealth technology and services. I agree to participate in the Telemedicine/telehealth services offered by Peter Christensen Health Center.

This informed consent will remain in force and effect for a period of **twelve (12) months** from the date below, unless I provide a written notice of the withdrawal of this consent.

Patient: ____ DOB: __________________

Signature of Patient:____ Date: __________

The above informed consent is given on behalf of **______________________________** because the patient is a minor or has been determined to be incompetent to give consent.

Signature of Parent or Legal Guardian: ____

Relationship to patient: **____ Date: _________**

Informed Consent Declination

I decline Telemedicine/telehealth services. I understand the risks and benefits as explained to me and accept the risks and consequences of declining.

Patient____ Date: ______________________

Should you have questions or concerns about completing this form, please contact an Appointment Coordinator at 715-588-3371.