WON JO, M.D. / JAVED SADIQ, M.D.

Informed Consent for Telemedicine Services

Telemedicine involves the use of telephone and/or electronic communications to enable a health care provider at a different location to assist in the evaluation, diagnosis, management and treatment of health care problems.

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 to ensure its integrity against intentional or unintentional corruption.

I understand the following:

1. The consulting health care provider will be at a different location from me. Other health care professionals, such as a medical assistant, may be present with the provider to assist in the consultation.
2. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to other entities without my consent.
4. I understand that I have the right to withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas.
6. A record of the consultation will be kept in my medical record.
7. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties.
8. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
9. I understand that that there are inherent limitations of telemedicine, including the inability to perform a physical exam, and that physical findings may not adequately be addressed.
10. I understand that my insurance may be billed for any interactions using telemedicine as appropriate.
11. I understand that I may be responsible for any co-pay/deductible/co-insurance for each consultation using telemedicine in accordance with the policies set forth by my insurance company.

If you agree to the terms above and wish to schedule an appointment with Dr. Jo or Dr. Sadiq, please reply via email stating that you have read this document and are giving consent to have your consultation conducted using telemedicine.

If you are unable to use email, a copy of this form with your signature can also be mailed or faxed to our office.

Patient Name: _____ DOB: _____

Signature: _____ Date: _____