JOHNS HOPKINS
MEDICINE

TELEMEDICINE ACKNOWLEDGEMENT

TELEMEDICINE/TELEHEALTH SERVICES ACKNOWLEDGEMENT

Patient Identification Information

Patient Name

Date of Birth

Telehealth services (also known as telemedicine, e.g. interactive video, remote video monitoring, store and forward, or other electronic media interactions) give you the ability to communicate with your healthcare team or your healthcare team to communicate with one another without having to be in the same physical location. You may communicate with your healthcare team using technology, such as a mobile device, tablet or computer.

Telehealth services are not an option for all of your care needs. Your provider may need to see you in person for certain medical conditions.

No video, audio or photo recordings will be taken of you in the course of telehealth services without your consent.

I UNDERSTAND THE FOLLOWING:

- I understand that I may see my healthcare team using this technology for some of my care needs.
- I understand that a telehealth provider who is not present in the room with me may provide a portion of my care.
- I understand that my telehealth provider may not perform an in-person physical examination of me at the time my telehealth services are provided.
- I understand that technology platforms used for telehealth sometimes malfunction. My healthcare team or I can stop or cancel a telehealth service if the technology is not working properly or if my healthcare team determines that the provision of telehealth services will not adequately address my medical needs.
- Generally, I have the right to cancel my telehealth service without affecting my ability to receive care in the future. There may be exceptions to my right to cancel the visit/consult due to clinical and safety reasons (e.g. remote video monitoring).
- A healthcare provider will explain to me how the telehealth services will be provided.
- I understand that the laws that protect privacy and the confidentiality of medical information also apply to telehealth services and that no information obtained in the use of telehealth services which identifies me may be disclosed to researchers or other entities or used as part of a research study without my consent, except as otherwise permitted by law.
- I understand that there are alternative forms of communication available between me and a physician for urgent matters.
- I may receive more than one bill related to my telemedicine services. I understand that my telehealth provider may be an independent consultant and that this consultation may result in separate charges from the telehealth provider. I also understand that my telehealth service provider may not be an employee of the hospital/health care facility from which I am receiving treatment. I further understand that I am responsible for the self-pay (co-pay, deductible, etc.) portion of all billing related to these interactions. I understand that if telehealth services are not a covered service by my insurer, I may be responsible for the entire bill.

PATIENT ACKNOWLEDGEMENT FOR TELEMEDICINE/TELEHEALTH SERVICES - I have read and understand the items as defined in the above Telemedicine/Telehealth Services Acknowledgement Form.

Date | Patient Signature | Patient PRINTED Signature

For D health care agent / D guardian / D surrogate / D parent (check one), I am the representative for the patient.

Date | Representative's Signature | Representative's PRINTED Signature