University Skin Institute
Medical, Surgical, and Cosmetic Dermatology

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# Telehealth Patient Consent Form

I (name) _____ agree to receive this health care service,

(service type) _____, as a telehealth service. I understand that the

health care practitioner (name) _____ is located in another facility.

(initial) _____ A telehealth service means that my visit with a practitioner at the distant site will happen by using electronic communications to provide patient care.

(initial) _____ The same confidentiality protections that apply to my other medical care also apply to Telehealth service.

(initial) _____ I will have access to all my medical information resulting from the Telehealth service as provided by law.

(initial) _____ I also understand that my insurance will be billed for this visit, and that I may be billed for what my insurance does not cover, dependent upon the provider. I understand that if I have questions about my billing, I will need to talk with the provider's billing office. Therefore, by signing this consent, I am giving permission to release my information to my insurance company or third-party payor.

By signing below, you understand and agree that you solely assume the risk of any errors or deficiencies in the electronic transmission of information during your telehealth visit or in the electronic submission of your images to your dermatologist and further understand that no warranty or guarantee has been made to you concerning any particular result related to your condition or diagnosis. To the extent permitted by law, you also agree to waive and release your dermatologist and his or her institution or practice from any claims you may have about this advice or the telehealth visit generally.

Signature of Patient _____ Date: _____

Signature of Parent/Guardian _____ Date: _____