Patient Name:__________________________Date of Birth:_________________Date of Service:____________

INFORMED CONSENT FOR TELEHEALTH CONSULTATION

PURPOSE: This form obtains your consent to participate in a telemedicine consultation, also known as "Telehealth" services. Telehealth is the delivery of health care services using two-way video communications and/or the electronic exchange of information. Since this is different than in-person health care services you may typically receive, it is important for you to understand and be aware of and comfortable with the benefits and possible risks. For your Telehealth visit, a Washington University or BJC Medical Group provider will communicate using electronic and video transmissions and will have access to your medical records while you are being treated at home. This will enable your provider to determine an appropriate treatment plan for your condition. Participating in this Telehealth program will give you access to your provider without having to travel to your provider's office, for inpatient/outpatient care.

Some possible risks associated with the use of Telehealth services include, but may not be limited to:

- Instances in which the electronic information may not be sufficient for appropriate medical decision making by the provider.
- Equipment issues, which could cause delays in your medical evaluation and treatment.
- Security measures could fail, possibly exposing your privacy and your personal medical information.
- Finally, in some cases, Telehealth services may not be as complete as in-person services, and if your provider believes an in-person visit is necessary, he or she may recommend that you schedule an in-person visit.

It is important that you understand and agree to the following statements:

1. I understand that engaging in a telemedicine visit with my health care provider at Washington University/BJC Medical Group is optional. I have the right to discontinue this service at any time. I further understand that in place of telehealth services, I may request a face-to-face visit with my health care provider.
2. I have been informed and understand the alternatives to the Telehealth services that are available to me, and give my consent to proceed with Telehealth services.
3. I understand that my provider will be at a different location from me. I understand that a telemedicine visit 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 the consulting health care provider and the provider will not be able to physically examine me.
4. I understand that the video portion of the telehealth service will not be recorded.
5. I understand that others may also be present during the visit other than my health care provider and consulting health care provider(s) in order to operate the video equipment and/or facilitate the Telehealth consultation. I further understand that I will be informed of their presence in the visit and thus will have the right to request the following: (1) omit specific details of my medical history/physical

examination that are personally sensitive to me; (2) ask other personnel to leave the telemedicine examination room; and/or (3) end the visit at any time.

6. I understand that I have the right to request a copy of this informed consent and upon request it will be provided to me.
7. I understand there is a possible risk of an incomplete or ineffective visit due to technological issues, and that if any of the technological issues occur, the visit may end. The technological issues include but are not limited to: a) failure, interruption or disconnection of the audio/video connection; b) a picture that is not clear enough to meet the needs of the visit; and/or c) a minor risk of access to the visit through the interactive connection by electronic tampering.
8. I understand that my provider or I can stop the telemedicine visit if the telehealth connections are not adequate for the situation.

ACKNOWLEDGEMENT & CONSENT: I have read and understand this consent. I have been given an opportunity to ask questions and all of my questions have been answered to my satisfaction. The risks, benefits, and alternatives of the Telehealth visit have been explained to me and I hereby consent to participate in Telehealth services as described in this document during this course of treatment.

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Signature of Patient or Person Authorized to Consent Date Relationship to Patient