INFORMED CONSENT FOR TELEMEDICINE SERVICES

Introduction: Telemedicine involves the real-time evaluation, diagnosis, consultation on and treatment of a health condition using advanced telecommunications technology, which may include the use of interactive audio, video, or other electronic media. As such, telemedicine allows the provider to see and communicate with the patient in real time.

Consent for Treatment: I voluntarily request Athens Dermatology Group (henceforth referred to as ADG) providers (physicians, advanced practice providers, medical assistants) to participate in my medical care through the use of telemedicine.

I understand ADG providers (i) may practice in a different location than where I present for medical care, (ii) may not have the opportunity to perform an in-person physical examination, and (iii) rely on information provided by me. I acknowledge ADG providers advice, recommendation, and/or decision-making may be based on factors not within their control, such as incomplete or inaccurate data provided by me or distortions of diagnostic images or specimen that may result from electronic transmissions. I acknowledge it is my responsibility to provide information about my medical history, condition and care that is complete and accurate to the best of my ability. I understand the practice of medicine is not an exact science and no warranties or guarantees are made to me as to result or cure.

I understand I will not be physically in the same rooms as my health care provider. I will be notified of, and my consent obtained for anyone other than my health care providers present in the room I understand I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and my refusal will be documented in the medical record. I also understand my refusal will not affect my right to future care or treatment. I understand the current laws protecting privacy and confidentiality of health care information apply to telemedicine services.

I understand my health care information may be shared with other individuals for scheduling and billing purposes. I understand my insurance carrier will have access to my medical records for quality review/audit. I understand I will be responsible for any out-of-pocket costs such as copayments, coinsurances, or deductibles applying to my telemedicine visit. I understand health insurance plan payment policies for telemedicine visits may be different from policies for in-person visits.

If ADG providers determine telemedicine services do no adequately address my medical needs, they may require an in-person medical evaluation. In the even telemedicine session is interrupted due to a technological problem or equipment failure, alternative means of communication may be implemented or an in-person medical evaluation may be necessary. If I experience an urgent matter, such as a bad rection to any treatment after a telemedicine session, I should alert my provider and, in the case of emergencies, dial 911 immediately.

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ATHENS DERMATOLOGY GROUP, P.C.

Release of Information: To facilitate the provision of care and/or treatment through telemedicine, I voluntarily request and authorize the disclosure of all and any part of my medical record (including oral information) to ADG providers. I understand and agree the information I am authorizing to be released may include: 1. HIV/AIDS test results, diagnosis, treatment and related information: 2) drug screen results and information about drug and alcohol use and treatment: 3) mental health information; and 4) genetic information

I understand the disclosure of my medical information to ADG providers, including the audio and/or video, will be by electronic transmission.

Although precautions are taken to protect the confidentiality of this information by preventing unauthorized review, I understand that electronic transmission of data, video images, and audio is new and developing technology and confidentiality may be compromised by failures of security safeguards and illegal and improper tampering.

I, the patient or patient's representative and ADG providers rendering or providing medical care, health care, or safety, professional and administrative services directly related to health care to patient, agree: (1) all health care rendered shall be governed exclusively and only by Georgia law and in no event shall the law of any other state apply to any health care rendered to the patient : and (2) in the even of a dispute, any lawsuit, action, or cause of which in any relates to health care provided to the patient shall only be brought in a Georgia court in the county/district where all or substantially all of the health care was provided or rendered (not received) and in no event will any lawsuit, action or cause of action ever be brought in any other state. The choice of law and forum selection provisions of this paragraph are mandatory and are not permissive.

Signature of Patient/Responsible Party (Relationship to Patient)	Time/Date

Patient Compliant Procedure:

While we hope that every patient's visit goes smoothly, it is important we are notified of patient concerns so that we can address them adequately. If you have comments, questions or concerns, we recommend you or your representative discuss them with your immediate caregiver or speak to the office manage. Complaints about providers licensed by the Georgia Composite Medical Board, may be reported for investigation at the following address:

Georgia Composite Medical Board, ATTN Investigations
2 Peachtree St, NW
6th Floor
Atlanta, Georgia 30303-3465

For more information, visit the Georgia Composite Medical board at https://medicalboard.georgia.gov/

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