Wichita Diabetes & Endocrinology LLC

CONSENT TO PARTICIPATE IN TELEHEALTH SERVICES

In order to reduce possible exposure to COVID-19 (Coronavirus), our practice is implementing (1) telehealth virtual visits via interactive video conferencing for established patients and (2) virtual check-ins by telephone and/or interactive video conferencing for established patients. This is a temporary measure in response to the COVID-19 virus.

Because this is in response to a national health emergency, the service used may not comply with all HIPAA Privacy and Security requirements.

1. Purpose. The purpose of this form is to obtain your consent to participate in a telehealth services provided by Wichita Diabetes and Endocrinology LLC.

2. Your Rights. You may withhold or withdraw your consent to the telehealth service at any time before or during the consult without affecting the right to future care or treatment.

3. Risks and Benefits. Please initial to indicate you have read each statement and understand it.

_____ I understand that there may be limitations to image quality or other electronic problems that are beyond the control of the provider.

_____ I understand that delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment.

_____ I understand that in some instances, security protocols could fail, causing a breach of privacy of personal medical information.

_____ I understand that telehealth is being utilized during the COVID-19 pandemic as a way to reduce potential exposure to the virus and that face-to-face encounters will resume once the risks associated with the virus have been minimized.

_____ I understand that there are no guarantees with telehealth services.

_____ The physician or clinic staff has answered all my questions.

By signing below, I agree that I have received an explanation of how the video and audio technology will be used to conduct the telehealth service, and I understand there are limitations to the technology and the process of telehealth, including the potential for incomplete exchange or loss of information. I understand and consent to participate in and be videotaped and recorded during the telehealth services. I understand the written information provided above, and I hereby voluntarily and freely agree and give my consent to take part in the telehealth service and to any related evaluation, assessment and diagnosis as the consulting health care provider deems appropriate for my current medical conditions and the consultation.

Signature of patient or patient's representative

Date/Time