Kidney and Hypertension Clinic of Alaska

Telehealth Patient Consent Form

Patient Name: _____Date of Birth: _____

A telehealth service means my visit with a Provider at a distant site will happen by using my internet, smart phone or tablet and a secure, HIPAA compliant platform, known as pMD.
This consent is valid for one year.

I understand that:

- I can decline the Telehealth service at any time without affecting my right to future care.
- If I decline the Telehealth services, I may be asked to come in for an in-person visit or my appointment may be rescheduled to a later date. (The other options for me, include seeking alternative providers in my community.)
- I may not be always given the option of telehealth visit, if Provider deems an in-person visit necessary, based upon my health.
- The same confidentiality protections that apply to my other medical care also apply to the Telehealth service.
- I will have access to all medical information resulting from the Telehealth service as provided by law.
- I will be informed of all people who will be present at all sites during my Telehealth service.
- The information from the Telehealth service (images that can be identified as mine or other medical information from the Telehealth Service) cannot be released to researchers or anyone else without my additional written consent.
- I also understand that my insurance will be billed for this visit and I am responsible for any co-pays, deductibles, or any outstanding amount my insurance does not cover. I understand if I have any 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 information to my insurance company or third-party payor.

I have read this document carefully, and my questions have been answered to my satisfaction. I understand this consent is valid for 1 year and will be renewed after _____.

I agree to receive this consultation/follow up visit service as a Telehealth service.

_____ _____

Signature of Patient/ Patient Representative **Date**

Provider Use Only
Form will expire on: _____ Staff Initials: _____ Date: _____