General Consent for Telehealth Services/Virtual Visit and Acknowledgements

Consent for Telehealth Services/Virtual Visit Care and Treatment

General Consent: I consent for Patient, which may be defined as me, my child or a person for whom I have legal responsibility, to receive care and treatment at a Texas Health Physicians Group facility, entity or program (collectively referred to as "THPG") through Telehealth Services (which may also be referred to as a Virtual Visit or Telehealth). Telehealth Services may be provided by physicians, advanced practice providers, and other health care providers employed or contracted by or affiliated with Texas Health Physicians Group ("Telehealth Providers") and may include the evaluation, diagnosis, consultation on, and treatment of Patient's medical or health condition using advanced telecommunications technology. I understand that photos or video of Patient may be taken in connection with Telehealth Services and for operational, quality improvement, research, and education purposes. I understand that THPG practices may be a teaching facility and agree that residents, fellows, students and other approved individuals may observe and participate in the Telehealth Services under appropriate supervision.

I understand that Telehealth Services include interactive audio, video or other electronic media and that there are both risks and benefits to being treated via Telehealth. Telehealth Providers (i) may be in a location other than where Patient is located, (ii) will examine Patient face-to-face via a remote presence but will not perform a "hands-on" physical examination, and (iii) must rely on information provided by Patient. I further understand that Telehealth Services may be limited or unavailable as a result of technological or equipment failures, incomplete or inaccurate data to perform the Telehealth Services, or distortions of images or other information from electronic transmissions. I acknowledge that the Telehealth Providers cannot be held liable for advice, recommendations and/or decisions based on factors not within their control, such as incomplete or inaccurate data provided by Patient/others or distortions of diagnostic images or specimens that may result from electronic transmission.

If the Telehealth Providers determine that Telehealth Services do not adequately address Patient's medical needs, Patient will be referred for on-site medical evaluation. If Patient's condition is urgent / emergent, or if the Telehealth session is interrupted due to a technological or equipment failure, I agree Patient will obtain follow up care and treatment as needed.

I understand that precautions are taken to protect the confidentiality of Patient's medical information by preventing unauthorized disclosure; however, I understand and acknowledge that the security of electronic transmission of data, video images, and audio information cannot be guaranteed and confidentiality may be compromised by illegal or improper tampering.

Independent Providers: The Telehealth Providers are independent physicians or providers who work for THPG and not Texas Health Resources.

No Guarantee: I acknowledge that no guarantees or warranties have been made as to treatment or services provided at Texas Health Physicians Group.

Notice of Complaints: To file a complaint or grievance with THPG, you may call 214-860-6427. A complaint regarding a physician Telehealth Provider may reported for investigation at the following address: Texas Medical Board, Attention: Investigations, 333 Guadalupe, Tower 3, Suite 610, P.O. Box 2018, MC-263, Austin, Texas 78768-2018, or by calling 1-800-201-9353, or by visiting their website at www.tmb.state.tx.us.

Text / Voice / Automated Messaging: I authorize THPG to send communications by text message, voice and automated calls to the cell phone number I provide. I acknowledge that standard data rates and fees will apply, full security is not guaranteed over telephone networks, and I will need to protect my phone with a password or PIN to prevent unauthorized access. I understand that text and automated messaging may not be used by me to notify THPG of Patient's health care needs.
Duration of Consent: I understand and agree this Consent for Telehealth Services Care and Treatment is valid for all Telehealth Services/Virtual Visits, for the present and future visits for one year from the date of signature below unless I revoke the consent prior to that time.

I have read and understand the information in this Consent for Telehealth Services/Virtual Visit Care and Treatment form, and understand that by not signing this Consent I will not be treated.

Patient Name: _____ Date of Birth: _____

_____ _____

Signature of Patient/Parent or Legally Authorized Representative* Date/Time

_____ _____

Printed Name of Patient/Parent or Legally Authorized Representative Relationship to Patient

*__Parent or Legally Authorized Representative must sign if Patient is under 18 years of age.__
__** Witness must be an adult, over the age of eighteen (18) years, of sound mind and not a participant in the medical treatment.__

Patient Name: _____

Date of Birth: _____

Protected Health Information - Notice of Privacy Practices: THPG *Notice of Privacy Practices* addresses how THPG may use and disclose Patient's Protected Health Information (PHI) for treatment, payment, and healthcare operations and for other purposes allowed or required by law. I acknowledge that I have received or been offered THPG *Notice of Privacy Practices* and that any questions or concerns may be directed to the THPG Privacy Officer, prior to this visit.
Use and Disclosure of information: I understand that Patient's medical records are confidential and cannot be disclosed without my written authorization except as authorized by law. Authorized disclosures are addressed in the Notice of Privacy Practices. I understand that Patient's medical information includes past, present and future information and may include genetic testing / counseling, communicable disease information including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), records related to mental health treatment/psychiatric care and alcohol/substance abuse diagnosis or treatment (collectively, "Medical Information"). I authorize release of that Medical Information as part of Patient's medical and billing records. I understand that THPG must keep Patient's medical records for a time period required by law and then may dispose of such medical records as permitted or required by law.

Electronic Sharing of Medical Information: I authorize THPG to use Patient's Medical Information for treatment, payment, and healthcare operations (collectively referred to as "Purposes"), or as otherwise allowed by law. I acknowledge that THPG will release and send, electronically or otherwise,

Patient's Medical Information to third parties for the Purposes set forth above, or as otherwise allowed by law. I understand that Medical Information may no longer be protected by federal and state privacy laws once it is disclosed, and therefore, may be subject to re-disclosure by the recipient. Medical Information may become part of Patient's medical records kept by non-THPG healthcare providers and may be further disclosed.

I have read and understand the information in the Acknowledgments for Protected Health Information and Financial Responsibility and have received THPG's Notice of Privacy Practices.

_____	_____
Signature of Patient/Parent or Legally Authorized Representative*	Date/Time
_____	_____
Printed Name of Patient/Parent or Legally Authorized Representative	Relationship to Patient

*__Parent or Legally Authorized Representative must sign if Patient is under 18 years of age.__
__** Witness must be an adult, over the age of eighteen (18), of sound mind and not a participant in the medical treatment.__