KIDNEY CARE

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CONSENT FOR TELEMEDICINE SERVICES

Patient Name: _____ **Date**: _____
Date of Birth: _____ (For security: Do not include if the form is emailed)
Patient Location: May be (1) Home (2) Office (3) Vehicle (4) Other: _____

Telemedicine employs electronic communication to enable healthcare clinicians to deliver medical services to individuals in different geographic places. During your telemedicine consultation, your medical history and personal health details may be discussed with you or other healthcare professionals.

This information could be used for diagnosis, treatment, follow-up, and education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Data from medical devices
- Sound and video files

Furthermore, with your consent, a **physical examination** might be conducted, and video, audio, and/or photo recordings may be taken.

The electronic systems used will **incorporate network and software security protocols** to protect confidentiality of patient information and imaging data, aiming to ensure data integrity against intentional or unintentional corruption. However, the communication mode used during telehealth consultations, **may not be entirely secure and could entail privacy risks.**

Expected Advantages:

- Convenience of medical care access, allowing patients to remain at their location while receiving care from a distant physician.
- More efficient medical evaluation and management.
- Limit the spread of communicable disease during epidemics and pandemics.

Potential Risks:

Telemedicine has potential risks /inefficiencies including, but not limited to:

- There may be a need for in-office visits for urine analysis, point-of-care ultrasound imaging, or an in-person exam. This may cause a delay in medical evaluation/treatment*.
- Insufficient information transmitted for effective medical decision-making due to factors like poor image resolution, potentially causing delays in treatment/evaluation*.
- Rare instances of security protocol failure, resulting in privacy breaches of medical information.
- Occasional lack of access to complete medical records, potentially resulting in drug interactions, allergic reactions, or other judgment errors.

*If delay of medical care is anticipated, a backup plan will be discussed. If the delay will affect the health or wellbeing of the patient, referral to urgent care or emergency room will be recommended.

INFORMED CONSENT FOR TELEMEDICINE:

By signing this form, I acknowledge the following:

1. Anticipated benefits can arise from telemedicine in my care, but results cannot be guaranteed.
2. Privacy and confidentiality laws apply to telemedicine, with efforts taken to protect health information privacy and security. Information identifying me won't be disclosed without consent.
3. During certain situations (e.g., COVID-19 Pandemic), security measures might be adjusted as per U.S. Department of Health and Human Services (HHS) guidelines to enhance care access.
4. I retain the right to withhold or withdraw telemedicine consent without impacting future care.
5. I can review all telemedicine interaction information and obtain copies for a reasonable fee.
6. Alternative medical care methods are available, with alternatives explained by the Practice.
7. Telemedicine may involve sharing personal medical information with clinicians in different areas, potentially including other states.
8. I should inform the Practice about electronic interactions with other healthcare providers.

9. My healthcare information may be shared for scheduling/billing. Others might be present during consultations for equipment operation, maintaining confidentiality.

PATIENT CONSENT TO TELEMEDICINE USE:

I have read and understood the telemedicine information provided. My questions have been addressed satisfactorily. I hereby consent to telemedicine use in my medical care, if indicated, and authorize Signature Kidney Care for telemedicine in my diagnosis and treatment.

Patient's Signature: _____ Date: _____
Print Name: _____

Guardian Signature _____ Date: _____
Authorized Signer's Relationship: _____