Consent for “Virtual” (Non-In-Person) Visits

Bethesda Medical Associates

Patient Name *

First Name Last Name

Patient Date of Birth *

Month Day Year

I, _____(name), hereby voluntarily consent to receive “virtual” care. I understand that this consent form will be valid and remain in effect for as long as I am receiving medical care at Bethesda Medical Associates.

Examples of the virtual services offered pursuant to this consent include:

Virtual check-ins: You and your treating provider may have a brief phone call to determine whether an in-person visit or other appropriate treatment is necessary.

E-visits: You may communicate with your treating provider through your patient portal or secure email.

Telehealth visits: You and your treating provider can use real-time interactive audio and video communication that permits real-time communication (such as FaceTime, Skype or What’s App) to conduct a visit while you and your treating provider are in different locations.

Phone Calls: Your treating provider may use communication with you via a phone call as a means to deliver a service comparable to an in-office visit.

"Virtual” or “Telehealth Visits" mean that you may be evaluated and treated by a health care provider or specialist from a distant location via electronic communication. Because this type of consultation may be different from that with which you are familiar, it is important you understand and agree to the following statements:

1. My treating provider will be at a different location from me. Additional medical or registration personnel may also be present in the room with the provider.
2. I understand that my voice and image may be recorded to assist in my treatment and I consent to any such audio and video recording.
3. I understand there are potential risks associated with this technology, including, but not limited to, interruptions, unauthorized access, technical difficulties, and call termination. I understand there are limitations to this type of care and that I may seek alternatives. I understand that my health care provider or I can discontinue the telemedicine consultation/visit if either party determines that the

videoconferencing connections are not adequate for my situation.

4. I understand that I may be disconnected before all my medical problems are known or treated. It is my responsibility to make such conditions or symptoms known to the medical personnel and to make arrangements for follow-up care.
5. I understand that standard deductible and coinsurance amounts apply to these “Virtual” or “Telehealth Visits” and I consent to virtual treatment.

Signature of Patient or Person Authorized to consent for patient *

I acknowledge and agree that my electronic signature affixed hereto is intended to authenticate this consent form and shall have the same force and effect as my handwritten signature.

Date *

Month Day Year