Synergy – An Integrative Medicine Center for Women, PLC
1036 Volvo Parkway, Suite 2
Chesapeake, VA 23320

Telephone Number 757.410.5462
Facsimile Number 757.410.5862

Telemedicine Informed Consent Form

I _____, consent to engaging in telemedicine with Synergy – An Integrative Medicine Center for Women, PLC. I understand that telemedicine may include health evaluation, assessment, consultation, treatment planning, and therapy. Telemedicine will occur primarily through interactive audio, video, telephone and/or other audio/video communications.

Permissible telemedicine services available to me include prescription refills, appointment scheduling and patient education.

I understand that the provider is responsible for determining whether or not the condition or conditions being diagnosed during this telemedicine encounter is appropriate for this form of interaction/communication.

I understand I have the following rights with respect to telemedicine:

- I have the right to withhold or remove consent at any time without affecting my right to future care or treatment, nor endangering the loss or withdrawal of any program benefits to which I would otherwise be eligible.

- The laws that protect the confidentiality of my personal information also apply to telemedicine. As such, I understand that the information released by me during the course of my teleconference/consultation is generally confidential. Both mandatory and permissive exceptions to confidentiality exist including but not limited to legal proceedings where information is requested by a court of law. I also understand that the dissemination of any personally identifiable images or information from the telemedicine consultation to other entities shall not occur without my written consent,

- I understand that telemedicine-based services and care may not be as complete and in-person services. I understand that if my provider believes I would be better served by other interactions, that I will be referred to a provider who can provide those services in my area. I also understand that there are potential risks and benefits associated with any form of health treatment, and that despite my efforts and efforts of my provider, my condition may not improve, or may have the potential to get worse.

- I understand that I may benefit from telemedicine services, but that results cannot be guaranteed or assured. I understand that the use of Skype, Facetime, GoToMeeting, and

#

Google audio/video systems are not 100% secure and may have issues with wifi connectivity. All attempts to keep information confidential while using these systems will be made but a guarantee of 100% confidentiality cannot be made with inherent issues with these communication systems. Signing this form reflects my awareness of these issues and a decision by me to use these systems for telemedicine services. To that end, I understand and agree that my provider and Synergy - An Integrative Medicine Center for Women have taken reasonable security measures to protect my personal health information such as, by way of example but not by limitation, date of service encryption, password-protected screen savers, encrypted data files, and other reasonable and reliable authentication techniques. I will not hold Synergy - An Integrative Medicine Center for Women, PLC, or its staff liable for and thereby indemnify the provider and Synergy - An Integrative Medicine Center for Women, PLC, against gathering or use of client information by these service providers and against information lost due to technical failures.

- I understand that certain risks unique and specific to telemedicine, including but not limited to, the possibility that telemedicine consultations or other communications by my provider to others regarding my treatment could be disrupted or distorted by technical failures or could be interrupted or could be accessed by unauthorized persons.

I understand I have the right to access my personal information. I have read and understand the information provided above. I expressly consent to the forwarding of information that identifies me as a patient to third parties. I have discussed these points with my provider, and all of my questions regarding the above matters have been answered to my approval.

By signing this document, I agree that certain situations specifically inclusive of emergencies are inappropriate for audio/video/computer based medical services. If I am in an emergency situation, I should immediately call 911 or go to the nearest hospital.

_____	_____
Signature of client/parent/guardian	Date
_____	_____
Printed name of client/parent/guardian	Relationship (If applicable)
_____	_____
Provider Name	Provider Credentials

#