ORTHOPEDICS NORTHWEST
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Telehealth Informed Consent Form

Telehealth services involve the use of secure HIPAA and HITECH compliant software that enables health care providers to deliver health care services to patients.

1. I understand that telehealth-based services may not be as comprehensive as in-person services, but that the same standard of care applies to a telehealth visit as applies to an in-person visit.
2. I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room.
3. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
    a. If it is determined that any equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telehealth visit and make other arrangements to continue the visit.
4. I understand that I have the right to refuse to participate or decide to stop participating in a telehealth visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
    a. I may revoke my right at any time by contacting our office at (503) 639-6002.
5. I understand that the laws that protect privacy and the confidentiality of health care information apply to telehealth services.
6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
    a. I understand that my insurance carrier will have access to my medical records for quality review/audit.
    b. I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telehealth visit.
    c. I understand that health plan payment policies for telehealth visits may be different from policies for in-person visits.
7. I understand that this document will become a part of my medical record.

By signing this form, I agree that certain situations including emergencies and crises are inappropriate for audio, video and/or computer-based services. If I am in crisis or I am experiencing a medical emergency, I should immediately call 911 or go to the nearest hospital or crisis facility.

By signing this form, I attest that I have personally read this form and fully understand and agree to its contents; I understand the risks, benefits and alternatives to telehealth visits shared with me in a language I understand; and I am located in the state of Oregon and will be in Oregon during my telehealth visit(s).

Patient's Signature _____ Date _____

Patient's Printed Name _____

Patient's Address (physical location during telehealth sessions) _____

Emergency Contact Name _____ Contact Telephone Number _____