



TELEHEALTH CONSENT

1. My health care provider or office staff has explained to me how the video conferencing technology will be used to engage in a telemedicine appointment and that it will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.
2. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine appointment if it is felt that the videoconferencing connections are not adequate for the situation.
3. I understand that should I choose to use data with my phone carrier, I am responsible for any fees incurred.
4. I am choosing to participate in a telemedicine appointment, and I understand that some of the normal procedures of an office visit exam may not be conducted.
5. I understand that billing will occur for these services as with any normal office visit and my insurance policy will determine whether the service is covered. I understand that it is my responsibility as the patient to verify with my insurance provider and assume responsibility for any in-network or out-of-network fees for telemedicine appointments with Student Health Services. I also understand that telemedicine appointments can and will be used towards my subsidized visits should I be both eligible for subsidized visits and have subsidized visits available for use.
6. I have had a communication with my provider or their office staff, during which I had the opportunity to ask questions regarding this telemedicine appointment process. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language which I understand.
7. I understand that if I need to cancel my appointment for any reason, I need to inform Student Health Services no later than 24 hours in advance of my appointment date/time by calling and leaving a message on the cancellation line at (517) 355-7707. I understand that if I no show for my appointment or am not available at the scheduled time, I may be ineligible for any future telemedicine appointments.
8. As a returning patient, I have previously signed the MSU Consent for Treatment and HIPAA Patient Responsibility Forms. I understand that I will not be in the office to sign any forms. I consent to the extension of the above forms on file.
9. If I have further questions regarding this consent or telemedicine appointments, I can email olin@msu.edu.

By signing this form, I certify that:

- I have read or had this form read and/or had this form explained to me.
- I fully understand its contents including the risks and benefits of Telemedicine.
- I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Signature: _____ Date: _____

Patient Name (Printed): _____ Date of Birth: _____

Patient MRN/APID: _____

Return this form to Olin Health Center (463 East Circle Drive) or olin@msu.edu.

Please keep in mind that communications via email over the internet are not secure. Although it is unlikely, there is a possibility that information you include in an email can be intercepted and read by other parties besides the person to whom it is addressed.