Shodair
CHILDREN'S HOSPITAL

Department of Medical Genetics
• Clinical Genetics • Cytogenics • Maternal Serum Screening
• Molecular Genetics • Newborn Screening Follow Up • Pharmacogenetics

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TELEMEDICINE INFORMED CONSENT

I understand the following:

- Telemedicine uses electronic communication systems that permit a health care provider at a distant location to provide treatment to me where I am located and/or consult with and advise my local health care provider in making and implementing decisions about the care provided to me.
- My medical history, physical examinations and earlier procedures may be discussed with the distant provider(s).
- My local health care provider may physically examine me while the distant provider watches through the telecommunications equipment. I can limit the examination at any time if it makes me uncomfortable.
- I understand and agree that me session may be interrupted or rescheduled if a more urgent patient care need arises.
- Authorized personnel may be in the room while the telecommunications equipment is in use.
- The telemedicine consultation will not be videotaped unless I have given my written consent to do so.
- If my condition worsens after leaving the hospital or clinic, I should return to my local health care provider or call my emergency medical service.

The main benefit of a video communications consultation is that the local health care provider and I can become quickly connected to medical services at a distant location while I stay near my home. Other benefits of this method of communications may include:

- I do not need to travel long distances to receive medical services
- Allowing a provider at a local site to make the best decision possible regarding my care.
- A distant provider or specialist, who may see me at another location for more treatment, will be familiar with my health history.
- My health care provider may be able to obtain information from a distant provider that may enable me to continue treatment at home.

Risks of telemedicine may include the following:

- Possible communications delay because of difficulty in telecommunications service or the need for an emergency consultation.
- Difficulty sending a clear picture to a distant provider.
- Possible loss of information because of equipment or communication line difficulties at either site.

Other treatment choices: I understand that instead of participating in telemedicine, I may choose:

- To have to travel to the city where the distant health care provider is located.
- Not to receive treatment; or
- Not to obtain or receive the additional or specialized health care advice that the distant health care provider might be able to provide.

Financial Agreement – I assume full responsibility for and agree to pay any charges incurred, regardless of insurance coverage. I agree that if this account is referred to collection, I will be responsible for all costs of collection.

Release of Healthcare Information: I authorize the hospital and anyone who provides services to release medical information to any third party or funding source which may be responsible for the costs of my care. I understand the purpose or need for the disclosure of this information is for the determination of benefits payable for the services provided to me by the hospital or provider.

Questions – I have had an opportunity to ask questions regarding the telemedicine consultation and they have been answered. I am satisfied with my understanding regarding the telemedicine consultation.

Patient: I have read and understand the above information and give my consent.

Patient's Legal Guardian: If the patient is unable to give consent because of mental infirmity, disability, or because the patient is a minor and the parent's consent is required for the telemedicine consultation, the patient's legal guardian should provide consent. As the below-named patient legal guardian, I verify that I have given my informed consent to this telemedicine consultation and that I act in the patient's behalf. I make all representations that the patient would under this form.

_____	_____	_____	_____
Patient / Legal Guardian	Relationship to Patient	Date	Phone Number
_____	_____		
Printed Patient Name	Patient DOB		

This authorization will remain valid for a period of 12 (twelve) months from the date of signature unless revoked by me before that time. This authorization may be revoked by sending such revocation in writing to the HIM Director at 2755 Colonial Drive, Helena, MT 59601. Shodair will comply with the revocation unless disclosure is required to effectuate payments for health care that has been provided or other substantial action has been taken in reliance on the authorization.