OPTIMUM
WELLNESS CENTERS

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Telehealth Consent Form

Submit Form Clear Form

Telemedicine is the delivery of healthcare services when the healthcare provider and the patient (the "Patient") are not in the same physical location and communicate through technology. Electronically transmitted information may be used for diagnosis, treatment, follow-up, prescription, or education and may include medical records, medical images, interactive audio, video and/or data communications, and output data from medical devices, sound and video files. The Patient understands the following with respect to telemedicine offered by Optimum Wellness Centers, (the "Practice"):

1. The Patient has elected to have a telemedicine visit instead of an in-office visit at the Practice. The Patient agrees that the Practice will determine whether the Patient's condition is appropriate for telemedicine and acknowledges that the Practice may recommend an in-person visit.

2. There are potential risks associated with the use of telemedicine, including, but not limited to: the information transmitted may be less comprehensive than that available from an in-person visit and result in decreased accuracy of diagnosis or medical decision-making; delays in medical evaluation or treatment could occur due to deficiencies or failures of the telemedicine equipment; and security protocols could fail, causing a breach of privacy. The Patient understands that telemedicine often involves electronic transmission of the Patient's protected health information ("PHI"). The Patient's PHI includes, but is not limited to, the Patient's identifying information; medical history; diagnoses; communications to and from the Patient's other health care provider(s); etc. The Patient understands that PHI may be lost due to technical failures, cyber intrusion or other issues disrupting the Patient's telemedicine visit or causing delays in response from the Practice. The Patient assumes these risks and holds the Practice and its providers harmless from any claims arising out of the use of telemedicine to conduct the visit.

3. The Patient understands that telemedicine visits may be recorded and that the laws that protect privacy and confidentiality of medical information also apply to telemedicine. The Patient understands that PHI obtained during the telemedicine visit will not be disclosed to other entities without the Patient's consent unless otherwise permitted by applicable law or in accordance with the Practice's Notice of Privacy Practices. The Patient has the right to withhold or withdraw consent for telemedicine at any time without affecting the right to the Patient's future care, treatment, benefits, or programs for which he or she is otherwise entitled. Any such withhold or withdrawal of consent shall be given in writing, and shall be deemed to be properly delivered upon receipt if sent by: (a) certified U.S. mail, return receipt requested, (b) facsimile, or (c) personal delivery with receipt, to the principal address of the Practice. The Patient understands that if others are present at Patient's location during the Patient's telemedicine visit, the confidentiality of the Patient's telemedicine visit may be compromised.

4. The Patient understands the alternatives to telemedicine as they have been explained, and in choosing to participate in a telemedicine visit understands that some parts of the exam may require physical testing to be performed at another location at the direction of the Practice.

5. THE PATIENT UNDERSTANDS IT IS POSSIBLE THAT HEALTH INSURANCE WILL NOT COVER THE TELEMEDICINE VISIT(S). THE PATIENT MAY ELECT TO PAY OUT OF POCKET FOR THE TELEMEDICINE SERVICES IF THEY ARE NOT COVERED BY HEALTH INSURANCE. THE PATIENT AGREES THAT IF THE HEALTH INSURER DOES NOT PAY FOR THE TELEMEDICINE SERVICES, THE PATIENT WILL BE RESPONSIBLE FOR PAYMENT. THE PATIENT FURTHER UNDERSTANDS THAT HE OR SHE IS RESPONSIBLE FOR ALL COST SHARING OBLIGATIONS (E.G., COPAYMENT, DEDUCTIBLE) REQUIRED BY THE HEALTH INSURANCE PLAN ("COST SHARING OBLIGATIONS"). ALL OUT-OF-POCKET EXPENSES ASSOCIATED WITH THE TELEMEDICINE VISIT, INCLUDING COST SHARING OBLIGATIONS AND PAYMENT FOR NON-COVERED SERVICES, ARE DUE PRIOR TO THE TELEMEDICINE VISIT IF SUCH AMOUNTS ARE KNOWN AT THAT TIME.

6. The Patient understands that a patient must be physically located in the State of Florida during his or her telemedicine consultation(s) and represents that the Patient is located in the State of Florida during the entirety of each telemedicine visit. The Patient understands that if he or she is not physically located in the State of Florida, the Practice may decline to treat him or her via telemedicine.

7. The Patient understands that the Practice and its providers are located in the State of Florida and provide telemedicine services within the State of Florida. The Patient agrees that the venue of any action or proceeding relating to, involving, or resulting from the telemedicine services offered or provided or enforcement of this Telemedicine Consent shall be in _____ County, Florida, regardless of the location where telemedicine services are provided to the Patient. The laws of the State of Florida will govern any such disputes and the Patient consents to jurisdiction in the State of Florida.

8. The Patient has been advised of all the potential risks, consequences and benefits of telemedicine. The Practice has discussed with him or her the information provided above and the Patient has had the opportunity to ask questions about the information presented on this form. All the Patient's questions have been answered, and he or she understands the information.

By signing this form, I, _____ , consent to telemedicine services to be rendered by the Practice. I represent and warrant that I am authorized to consent to services described herein.

_____ Date: _____

Signature of patient or patient's representative