UK HealthCare

Lexington, Kentucky

CONSENT FOR CARE USING TELEHEALTH

(Patient Label Here)

Physicians, and other medical personnel such as physician assistants and advance practice registered nurses, and other types of providers such as registered nurses, speech-language pathologists, physical therapists, dieticians, psychologists, pharmacists, occupational therapists, optometrists, social workers, and behavioral analysts are called "providers" on this form.

I understand that the University of Kentucky teaches and trains doctors, nurses and other health care providers. Doctors in training (fellows, residents, interns, and house staff), medical students and other healthcare trainees may be involved in my care with appropriate supervision.

Instructions to patient: When this consent form is explained to you, please ask any questions you may have. If you do not understand the answers, please ask again until you do understand.

Telehealth will be used for the following departmental / specialty services: _____.

My provider has told me there could be problems when using telehealth. Possible problems include:

- A telemedicine exam may not give the information needed to make a clinical decision.
- Technology problems may delay medical evaluation and treatment for the telehealth visit.
- Security measures may fail, causing a breach of privacy of personal medical information. This is very rare.
- Telehealth does not provide direct treatment, including emergency care.

For Direct-to-Consumer telehealth patients:

- Lack of privacy at the patient's location or because the patient may use a non-secured or shared device.
- Interruption of the visit due to local factors or technology problems.

My provider has also told me about the possible benefits of the procedure. Possible benefits include:

- Improved access to care. A patient can get services from anywhere in Kentucky.
- A patient can stay close to home, working with local healthcare providers to maintain continuity of care.
- Less time and expense for travel.

I understand the originating site provider may provide certain services using telehealth technology, including transmission of images, video and audio that are encrypted for privacy. I understand that these images will be used for diagnosis, treatment or consultation, as well as for educational purposes only within UK HealthCare.

I understand that someone from the University of Kentucky may contact me in the future to ask me about my health or to take part in research.

By signing below, I understand the following:

1. This consent is in addition to any consent I gave for the care I am receiving.
2. This consent is for all the visits that include telehealth, and is valid for up to one year.
3. I am receiving telehealth services at the location of my choice, and I assume the risks that were discussed with me.
4. The laws that protect privacy and confidentiality of medical information also apply to telehealth. I have been given a copy of UK HealthCare's Notice of Privacy Practices.
5. I have the right to withdraw my consent to the use of telehealth in the course of my care at any time. This will not affect my right to future care or treatment.
6. My provider will determine whether the condition being diagnosed or treated is appropriate for telehealth. If my provider believes I would be better served by a traditional in-person office visit, he or she may at any time stop the telehealth visit and schedule an in-person visit for certain diagnosis and treatment or in the event of a technical failure.
7. No results are guaranteed or promised by using telehealth for care.
8. I or my insurance may be billed for telehealth services. I am responsible to the University of Kentucky and Kentucky Medical Services Foundation, Inc. (KMSF) for charges resulting from the services rendered using videoconferencing technology at their prevailing rates.

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9. If my provider sees or hears anything that shows I have an emergency medical condition, he or she may call 911.
10. Law may require my provider to report certain events, such as self-neglect or if someone is in danger.

NOTE: Interpretive services **must** be offered for preferred languages other than English.

I have read this consent form, and it has been explained to me. I have received information regarding telehealth and have had the chance to ask all of the questions I have about telehealth, its alternatives, its risks, its benefits, and limitations. I have been given answers to my questions, and I understand the answers.

Signatures

_____
Patient

_____
Signature of Legal Representative and Relationship to Patient

_____ _____
Person obtaining consent Date / Time

_____
Interpreter Name or ID # In person or via Cyracom (circle one)