BRUMMITTE DALE WILSON, M.D. & ASSOCIATES
DERMATOLOGY, MOHS SURGERY, AESTHETIC & LASER SURGERY
Brummitte Dale Wilson, M.D. * Cornelie M. Jones, M.D. * Peter SantaLucia, M.D.
CERTIFIED BY THE AMERICAN BOARD OF DERMATOLOGY

Telemedicine (Videoconferencing) Consent

1. I authorize **PETER SANTALUCIA, MD** to allow me[1] to participate in a telemedicine (videoconferencing) service with ❑ FaceTime ❑ Zoom ❑ Other _____
2. The type of service to be provided by via telemedicine is: _____
   _____
3. I understand that this service is not the same as a direct patient/healthcare provider visit, because I will not be in the same room as the healthcare provider performing the service. I understand that parts of my care and treatment which require physical tests or examinations may be conducted by providers and their staff at my location under the direction of the telemedicine healthcare provider.
4. The nature and purpose of the videoconferencing technology have been fully explained to me. I have also been informed of expected risks, benefits and complications (from known and unknown causes), discomforts and risks that may arise during the telemedicine session, as well as possible alternatives to the proposed sessions, including visits with a physician face-to-face. The risks of not using telemedicine sessions have also been discussed. I have been given an opportunity to ask questions, and all of my questions have been answered fully and satisfactorily.
5. I understand that there are potential risks to the use of this technology, including but not limited to interruptions, unauthorized access by third parties, and technical difficulties. I am aware that either my healthcare provider or I can discontinue the telemedicine service, if we believe that the videoconferencing connections are not adequate for the situation.
6. I agree to permit my healthcare information to be shared with other individuals for the purpose of scheduling and billing. I agree to permit individuals other than my healthcare provider and the remote healthcare provider to be present during my telemedicine service to operate the video equipment. I further understand that I will be informed of their presence during the telemedicine services.
7. I acknowledge that I have the right to request the following:
   a. Omission of specific details of my medical history/physical examination that are personally sensitive, or
   b. Asking non-medical personnel to leave the telemedicine room at any time, or
   c. Termination of the service at any time.
8. When the telemedicine service is used during an emergency, I understand that it is the responsibility of the telemedicine provider to advise my local healthcare provider regarding necessary care and treatment. It is the responsibility of the telemedicine provider to conclude the service upon termination of the videoconference connection.
9. I understand(s) that I will be billed by both the local healthcare provider **and** if applicable the telemedicine healthcare provider.
10. My consent to participate in this telemedicine service shall remain in effect for the duration of the specific service identified above, or until I revoke my consent in writing.

[1] The words "I", "me" "my" and "you" refer to the patient or the individual who has legal authority to act and consent for the patient.

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11. No guarantees or assurances have been made about the results of this service.
12. I confirm that I have read and fully understand the above information. All blank spaces have been completed prior to my signing. I have crossed out any paragraphs or words above which do not pertain to me.

VERBAL CONSENT AUTHORIZED BY: ❑ Patient ❑ Relative ❑ Guardian

_____
Print Name

_____ _____
Relationship to Patient Date/Time

_____ _____
Witness Date/Time

_____ _____
Interpreter (if required) Date/Time

I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives to (including no treatment) the proposed telemedicine session, have offered to answer any questions and have fully answered all such questions. I believe that the patient/relative/guardian fully understands what I have explained and answered.

_____ _____
Physician's Signature Date/Time

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