Telemedicine Consent Form

Informed consent for telemedicine services

I hereby agree to participate in a telemedicine evaluation, as a **current patient** of Chicken Soup Chinese Medicine.

I authorize the electronic transmission of my medical information and/or videoconference session so that it can be viewed by a Chinese medicine doctor, acupuncturist or other practitioner involved in my medical care.

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 consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my health care provider and consulting health care provider in order to operate the video equipment. The abovementioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room: and or (3) terminate the consultation at any time.

I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.

I understand that as with any technology, telemedicine does have its limitations. There is no guarantee, therefore, that this telemedicine session will eliminate the need for me to see a medical professional in person.

I agree that certain situations including emergencies and crises are inappropriate for audio/video/computer-based psychotherapy services. If I am in crisis or in an emergency I should immediately call 911 or go to the nearest hospital or crisis facility.

I understand that medical records of telemedicine services will be kept to ensure continuity of care and help facilitate treatment.

Chicken Soup Chinese Medicine
2325 3rd Street, Suite 342, San Francisco, CA 94107
phone 415-861-1101 • fax 415-644-0614 • email chickensoupchinesemedicine@docmisha.com
• www.docmisha.com

By signing this form, I certify that I have read this form and fully understand its contents including the risks and benefits.

I am determining my **consent** by selecting one of the following: ❑yes ❑ no

I am requesting a telemedicine visit primarily for:

- ❑ Immune Support and Prevention
- ❑ Preventative Health
- ❑ Other: _____

Full Name: _____ _____
(First) (Last)

Address: _____
(Street address)

_____ _____
(City) (State/Province)

_____
(Postal/Zip Code)

Please **take a photo of your government issued ID or Driver's License** and submit it with this form.
By law, we need to verify your identity for all telemedicine visits.

Phone number: _____ - _____
(Area code) (Phone number)

Email: _____
(example@example.com)

Signature: _____

Date & Time of Consent: _____ - _____
(Date) (Time)

Chicken Soup Chinese Medicine
2325 3rd Street, Suite 342, San Francisco, CA 94107
phone 415-861-1101 • fax 415-644-0614 • email chickensoupchinesemedicine@docmisha.com
• www.docmisha.com