Informed Consent for Telemedicine Services

Patient Name:_____ Date:_____
Date of Birth:_____
Physician Name:_____

I understand the telemedicine is the use of electronic information and communication technologies by health care provider to deliver services to an individual when he/she is located at a different site that the provider: and I hereby consent to NeuroSpine Institute providing health care services via telemedicine. I understand that the laws that protect privacy and the confidentiality of the medical information also apply to telemedicine. As always, your insurance carrier will have access to your medical records for quality review/Audit. I understand that I will be responsible for co-payments or co-insurance that apply to telemedicine visit. I understand I have the right to withhold or withdraw my consent to the use of telemedicine visit. I understand that I at any time without affecting my right to future care or treatment. I may revoke my consent in writing by contacting NeuroSpine Institute 1120 West Avenue M4 Palmdale CA 93551. As long as this consent is in force NeuroSpine Institute may provide health care services to me via telemedicine without the need for me to sign another consent form.

Signature of Patient or
Person authorized to sign for patient_____ Date:_____

If authorized signer, relationship to patient:_____

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