Informed Consent for Telemedicine Services

Introduction

Telemedicine involves the use of electronic communications to enable health care professionals at locations other than a patient’s to provide care to that patient. Providers may include primary care practitioners, specialists, and/or subspecialists. The information communicated may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Still photos
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files
Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to preserve its integrity against intentional or unintentional corruption.

Limitations of iNeuro Headache Specialist Telemedicine service (“iNHSTs”)

The purpose of iNHSTs is to provide a method, in appropriate circumstances, for Dr. Chehrenama to provide patients with diagnoses or treatments or both. Such clinical use of iNHSTs may not be lawful in every jurisdiction or in every clinical circumstance. Clinical use of iNHSTs may not be medically appropriate in some clinical situations. If you decide to become a patient, you acknowledge that, in the exercise of her clinical judgment, Dr. Chehrenama may determine that 1) the nature of your problem is such that it is not professionally appropriate to assist you with that problem through iNHSTs; or 2) it may not be lawful for Dr. Chehrenama to diagnose or treat you through iNHSTs; or 3) both. Should she make any such determination, she will be unable to assist you through iNHSTs and will confer with you about other possible approaches.

Emergencies

iNHSTs is not intended for use in emergencies. If you think you have or may have a medical or mental health emergency, you agree to call your health professional or the appropriate emergency contact number in your location.

Primary Care

If you decide to become a patient of iNHSTs, you represent and warrant that you have a primary care physician, and you understand and agree that iNHSTs is providing only limited non-emergency services that are not a substitute for, nor intended to substitute for, the advice of your primary care physician or of other qualified health care professionals.

You understand that you should never delay seeking advice from your primary care physician or other health professionals because of information provided through iNHSTs. You agree that you will seek emergency help when needed, or when you think there is some chance it may be needed, and that you will continue to consult with your primary care physician as he or she recommends.

Privacy

Because no data transmission is completely secure, iNHSTs cannot guarantee the security of the information you send to us or the security of our servers or databases, and by using iNHSTs you agree to assume all risk in connection with the information sent to iNHSTs or collected by iNHSTs when you use it. In the unlikely event that iNHSTs believes that the security of your information in its possession or control may have been compromised, iNHSTs may seek to notify You through iNHSTs or otherwise via your mobile or other device.
Patient Code of Conduct

In using iNHSTs, you agree to comply at all times with the following code of conduct:

You must use an iPhone/iPad/Android phone/Android tablet/webcam with a high quality Wifi or cellular connection (A minimum cell network quality of 4G capability is recommended.) You are responsible for ensuring that your Internet connectivity meets these specifications before using iNHSTs services.

You must truthfully identify yourself and your location.

You may not impersonate, imitate, or pretend to be another person when conferring with iNHSTs, nor knowingly allow another person to impersonate, imitate, or pretend to be you.

You must truthfully state your age.

You must identify anyone else who may be present in the room where you are located at the time of your consultation with iNHSTs.

It is your duty to inform iNHSTs of care that you may have received or are currently receiving from other healthcare providers, as well as any prescription or non-prescription medication you are currently taking.

You acknowledge that iNHSTs will rely upon your representations.

You must recognize that confidentiality can be compromised if it is not carefully handled, and sometimes even when it is, and so you must take reasonable steps to maintain confidentiality with respect to your communications with iNHSTs.

You agree to use iNHSTs for lawful purposes only and you acknowledge that your failure to do so may subject you to civil or criminal liability or both and to termination of your privilege to utilize iNHSTs.

You understand that you, and not iNHSTs, are responsible for ensuring that your use of iNHSTs’s services is in compliance with all applicable laws and regulations in your jurisdiction.

Children 13 to 18 years of age

If you wish to allow Dr. Chehrenama to diagnose or treat a child aged 13 to 18, except where under applicable law at the site of treatment parental consent is not required, You must, at the time and for the duration of your communication with iNHSTs, be physically present with the child. You must identify yourself as the child’s parent or guardian. You must decide whether, on your child’s behalf, to grant informed consent to care and treatment by iNHSTs.

In certain circumstances determined by law in certain jurisdictions, a child aged 13-18 is
himself or herself deemed capable of granting informed consent, independent of a parent or guardian. Dr. Chehrenama will determine whether those circumstances apply to the case of any given child aged 13-18. Where they do, your consent is neither required nor, without your child’s assent, may it be sought, nor, without your child’s consent, is your presence permitted, during the communication between the child Dr. Chehrenama.

**Expected Benefits:**

- Improved access to medical care by enabling a patient to remain in his/her location while the physician evaluates the patient’s problems at her own site
- More efficient medical evaluation and management
- Obtaining expertise of a distant specialist.
- Greater convenience and less need to travel for care.

**Possible Risks:** (As with any medical procedure or method, there are potential risks associated with the use of telemedicine. Among the most important are the following:

- Information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s)
- The physical examination Dr. Chehrenama can perform through iNHSTs is necessarily more limited than that which is possible in in-person care, so information that can be obtained only by means of an in-person physical examination will not be available to permit diagnosis. That risk is greater among those patients whom Dr. Chehrenama has not seen in-person than it is among those she has. This could result in misdiagnosis, which in turn could lead to treatment that is not helpful, or that could even be harmful.
- Delays in or interruption of medical evaluation and treatment could occur owing to deficiencies or failures of the equipment
- Security protocols could fail, causing a breach of privacy of personal medical information
- (A lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors
- In some cases, applicable law may prevent iNHSTs from providing the services you desire.

Moreover, since telemedicine remains a relatively new approach to care, risks not yet identified, possibly significant, could also exist.

Please initial after reading above __________
By signing this form, I understand the following:

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.

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 anytime, without affecting my right to future care or treatment.

I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction, and may receive printed copies of this information for a reasonable fee.

I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time.

I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.

I understand that it is my duty to inform my medical provider of electronic and non-electronic interactions regarding my care that I may have with other healthcare providers.

I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

Patient Consent To The Use of Telemedicine

I am not under the influence of any medications or other substances that could impair my understanding of the information in this document. I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction in terms I understand. At the time I of my signature, there are no unfilled blanks in this document. I hereby give my informed consent for the use of telemedicine in my medical care.
I hereby authorize Dr. Mahan Chehrenama at iNeuro Headache Specialist to use telemedicine in the course of my diagnosis and treatment.

________________________________________________________

Signature of Patient/ Date (or person authorized to sign for patient):

If authorized signer, relationship to patient:

________________________________________________________

Electronic acceptance of this document is equivalent to the Signature of Patient.

I have been offered a copy of this consent form (patient’s initials) ____