Michigan Foot & Ankle Specialists

7243 Chase Road Dearborn, MI 48126
Phone (313) 582-6222 Fax (313) 582-0166

Alexander P. Thomas, D.P.M

Instructions on submitting the telemedicine consent form

For you convenience we have the following methods available for deliverance of form once completed by patient or guardian.

1. Fax Number (313) 582-0166
2. Email directly to: Fax.MFAS@gmail.com

Please contact our office directly for any additional questions or concerns (313) 582-6222.

Thank you,

Alexander Thomas, DPM

Michigan Foot & Ankle Specialists

Alexander P. Thomas, D.P.M

Consent for Telehealth Services

Patient Name: Location of the Patient:	Date of Birth:
Provider Name: **Dr. Alexander P. Thomas** Site/Location:	Date Consent Obtained:

Introduction:

Telehealth involves the use of medical information exchanged from one site to another via electronic communications. Providers provide services using an interactive audio and/or video telecommunication system that permits real-time communication to persons who are at some distance from the provider.

Purpose: The purpose of this form is to obtain your consent to participate in telemedicine consultation in connection with the following procedures(s) and/or service(s):

_____

_____

Privacy and Security: I understand that for this encounter, electronic systems used will incorporate network and software security protocols as approved by Federal and State regulations, to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption. I understand and acknowledge that security protocols could fail, causing a breach of privacy of personal medical information.

Nature of Telehealth Consultation: I consent to Dr. Alexander P. Thomas; I have spoken to the patient care coordinator who explained to me how the video and conferencing technology will be used for the purposes outlined below:

1. Details of your medical history, examinations, and tests will be discussed through the use of interactive video, audio, and telecommunication technology.
2. Diagnosis, treatment plan, patient education, and follow up when/if needed.
3. A physical examination of you may take place.
4. Video, audio, and/or photo recording may be taken during the encounter.
5. Non-medical technical personnel may be present in the telehealth area to aid in video transmission

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

Alternatives: 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. My Provider has explained the alternatives to my satisfaction.

Risks and Consequences: The telehealth consultation will be similar to a routine medical office visit, except interactive video technology will allow you to communicate with a Provider at a distance. At first, you may find it difficult or uncomfortable to communicate using video images. The use of video technology to deliver healthcare and educational services is a new technology and may not be equivalent to direct patient to Provider contact. Following the telehealth consultation, your Provider may recommend a visit to our clinic or your local hospital for further evaluation.

Michigan Foot & Ankle Specialists

Alexander P. Thomas, D.P.M

Rights: I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, 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 telehealth interaction, and may receive copies of this information for a reasonable fee. I understand that it is my duty to inform my Provider of electronic interactions regarding my care that I may have with other healthcare providers.

I have had a direct conversation with the above doctor and/or patient care coordinator, during which I had the opportunity to ask questions concerning telehealth service. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand. All blanks or statements that required completion were completed before I signed this form.

I hereby consent to participation in a telehealth consultation.

_____ _____ / _____ / 2020
Signature of Patient **Date**

_____ _____
Signature of Authorized Representative **Relationship to Patient**

**********Office Use Only **********

_____
Printed Name and Signature of Provider or Patient Care Coordinator

_____:_____ AM / PM _____ / _____ / 2020
Time **Date**