dermatology SOLUTIONS

Informed Consent for Telemedicine/ Virtual Clinic Consultations

Please read and sign this consent form before your Telemedicine/Virtual Clinic consultations.
"Virtual Clinic" is an evaluation by a healthcare provider or specialist from a remote location through an electronic device, such as a smartphone, tablet, or computer. Because this is different than a consultation in the conventional medical office setting, it is important that you understand and agree to the following statements:

- The consulting healthcare provider will be at a different location from me. Additional medical or registration personnel may also be present in the room to assist the provider.
- I understand that my voice and image may be recorded in order to assist the medical or registration personnel. I hereby consent to any such audio and video recording.
- I understand there are potential risks to this technology, including, but not limited to, interruptions, unauthorized access, technical difficulties, blurry images, and call termination. I also understand there are alternatives and limitations to this type of care.
- I understand that either the healthcare provider or I may discontinue the telemedicine consultation/visit if it is felt that video conferencing connections are not adequate for my situation.
- I understand that I may be released before all my medical problems are known or treated, and it is my responsibility to make such conditions or symptoms known to the medical personnel as well as to make arrangements for follow-up care.

Authorizations
The undersigned patient, or authorized individual acting on behalf of the patient, understands and agrees as follows:

- By signing my name below, I am granting permission to all physicians, therapists, laboratories, and any other professionals to perform and administer care and treatment of the patient, or designated other qualified healthcare providers for such services.
- Grants permission to release to third party payor(s), Medicare, their representatives and/or physician(s) involved in the patient's care, any information needed in connection with all care rendered to the patient.
- If the patient is under the age of 18 or lacks capacity, the signing party affirms that they are either the parent or legal guardian of such patient and has full legal authority to seek medical assistance on behalf of the patient.

Financial Responsibility
I and/or my insurance carrier(s) agree to pay, in a timely manner, for healthcare services provided. I authorize payments directly to Dermatology Solutions LLC for all benefits payable. I understand that some private and government insurers do not include coverage for this service as a "Covered Service". I understand that I am responsible for any unpaid bills not covered by Medicare and/or any other private insurance company(s).

Signature _____ Date _____

Patient Guardian (if applicable) _____ Date _____

Please Mail/ Email/ Fax completed form to:
Mail: Dermatology Solutions LLC, 4915 E. Baseline Rd Ste 124, Gilbert, AZ 85234
Email: info@dermsolutionsaz.com
Fax: 480 832-2077