CYPRESS DERMATOLOGY

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Telemedicine Consent

As the State of Texas responds to COVID-19, private insurance companies are mandated to cover telemedicine. We are committed to providing you with quality and affordable health care during this challenging time.

I have requested to take part in a telemedicine consultation with Cypress Dermatology and its physicians, associates, technical assistants and others deemed necessary to assist in my medical care through a telemedicine consultation.

I understand the following:

1. The purpose is to asses and treat my medical condition.
2. The telemedicine consult is done through a two-way video link-up whereby the physician or other health provider at Cypress Dermatology can see my image on the screen and hear my voice. However, unlike a traditional medical consult, the physician does not have the use of the other senses such as touch or smell.
3. Since the telemedicine consultants' practice in a different location and do not have the opportunity to meet with me face-to-face, they must rely on information provided by me or my onsite healthcare providers.
4. I can ask questions and seek clarification of the procedures and telemedicine technology.
5. I can ask that the telemedicine exam and/or videoconference be stopped at any time.
6. I know there are potential risks with the use of this new technology. These include but are not limited to:
    - interruption of the audio/video link
    - disconnection of the audio/video link
    - A picture that is not clear enough to meet the needs of the consultation
    - electric tampering
7. If any of these risks occur, the procedure visit might need to be stopped and rescheduled.
8. If you are using your insurance for your telemedicine visit, a $75 deposit, or your co-pay will be collected at the time your appointment is made, whichever is higher. If the telemedicine visit is covered by your insurance and your deposit amount is higher than the amount allowed by the insurance company for your visit, the difference between the copay and deposit will be refunded using the original method of payment upon receipt of your EOB from your insurance company.

I, the undersigned patient, do hereby understand and state that I agree to the above terms.

I certify that this form has been fully explained to me. I have read it or have had it read to me. I understand and agree to its contents. I volunteer to participate in the telemedicine examination performed by Cypress Dermatology.

Signature: _____ Date: _____

Printed name: _____

Interpreter (if applicable): _____