The Skin & Wellness Center
26081 Merit Circle Suite 109, Laguna Hills, CA 92653
Telephone (949) 582-7699 Fax (949) 582-7691
Telehealth Email : Ann@aderm.us
Telehealth Cell for Texts: 949-229-2552

Telehealth/ Telederm

PLEASE COMPLETE ALL SECTIONS AND RETURN TO SENDER

Patient name: _____
DOB: _____
Today's Date: _____
Address: _____
Cell Phone: _____
Email: _____

ENCOUNTER REQUESTED : Video Non-Video

ALLERGIES:_____
_____
_____

MEDICATIONS:_____
_____
_____

CLINICAL HISTORY:

-Reason for consultation:

- Diagnosis_____
- Confirmation of diagnosis_____
- Recommendations for management_____
- Assumption of care_____
- Medical evaluation_____
- Hospitalization evaluation_____
- Disposition/duty status question_____
- Treatment recommendations_____

Patient verbally consented to a telehealth encounter after patient was informed of visit limitations with the use of technology and technical failures that may interrupt or stop the video connection during the course of the encounter. Patient was informed of their right to withhold or withdraw their consent to use of telehealth in the course of their care at any time. This may be a telehealth visit due to the Coronavirus national emergency, or a visit occurring thereafter. This medical document was created using an electronic medical record system, dictation, Microsoft word dictation, or with dragon computerized dictation system. Although this document has been carefully reviewed, there may still be some phonetic typographical errors. There areas are purely typographical due to imperfections of the software programs and do not reflect any compromise in the patient's medical care.

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Other_____
_____

-Duration: months, years, unknown, other _____
_____
-Skin Symptoms: pruritus, pain, none, other _____
_____
-Systemic symptoms?_____
_____
-Location? Specify
_____
_____

-Previous therapy? Specify _____
_____
-Known allergies? Specify _____
_____

Suggested Images (FIVE photos for each Question):

A: Take front, back and side views if the condition is widespread. Sometimes this view may not be necessary.
B: Use these views to illustrate the worst or most characteristic areas of the rash (e.g. elbows, knees, scalp in Psoriasis)
C: Detailed close ups of characteristic areas of the rash (i.e. to illustrate redness, pigment loss, crust, scale, surface detail)

Patient hereby consents to a telehealth encounter. Patient is hereby informed of visit limitations with the use of technology and technical failures that may interrupt or stop the video or non-video connection during the course of the encounter. Patient was informed of their right to withhold or withdraw their consent to use of telehealth in the course of their care at any time. This may be a telehealth visit due to the Coronavirus national emergency, or a visit occurring thereafter.

Date _____ Patient's Signature_____

Patient verbally consented to a telehealth encounter after patient was informed of visit limitations with the use of technology and technical failures that may interrupt or stop the video connection during the course of the encounter. Patient was informed of their right to withhold or withdraw their consent to use of telehealth in the course of their care at any time. This may be a telehealth visit due to the Coronavirus national emergency, or a visit occurring thereafter. This medical document was created using an electronic medical record system, dictation, Microsoft word dictation, or with dragon computerized dictation system. Although this document has been carefully reviewed, there may still be some phonetic typographical errors. There areas are purely typographical due to imperfections of the software programs and do not reflect any compromise in the patient's medical care.

Consent to Use Telemedicine

Patient's Name_____ My Doctor's Name_____

CONSENT TO USE TELEMEDICINE

I am physically located in California. At the beginning of each telemedicine session, I will help my doctor to complete a check-in to assess the suitability of using telemedicine services by verifying my full name, my current location, my readiness to proceed, and whether I am in a situation conducive to private, uninterrupted communication. By signing this consent, I understand and agree:

1. My doctor is located in and licensed by the State of California. My doctor may not be able to prescribe medications for me and/or may not be able to assist me in an emergency situation when I am located in any other state or country. If I require medication, I may contact my doctor. If I require emergency care, I may call 911 or proceed to the nearest hospital emergency room for help.

2. I submit to the exclusive jurisdiction of the California state superior courts and agree that any claim, lawsuit, or other legal proceeding arising out of or relating to the telemedicine services provided by my doctor and my doctor's staff will be brought solely and exclusively in California state superior courts. I also agree that the interpretation of this consent will be exclusively governed by and construed in accordance with the laws of California.

3. My doctor believes that telemedicine services are appropriate for my medical condition and that I would benefit from its use despite its risks and limitations. While I may expect anticipated benefits from the use of telemedicine, no specific results can be guaranteed or assured.

4. If my doctor believes at any time that another form of services (for example, a traditional in-person consultation) would be appropriate, my doctor may discontinue telemedicine services and schedule an in-person consultation with my doctor or refer me to a healthcare provider in my area who can provide such services.

5. I have the right to withdraw consent to the use of telemedicine services at any time and receive inperson healthcare services with my doctor.

6. I received an explanation of how the electronic communications technology will be used for the telemedicine services. I am comfortable with using electronic communications technology to communicate with my doctor and understand there are limitations to the technology which may require an in-person consultation.

7. I agree to have the necessary computer, equipment and internet access for my telemedicine communications. I also agree to arrange for a location with sufficient lighting and privacy and is free from distractions and intrusions during my telemedicine communications.

8. The laws that protect privacy and the confidentiality of my medical information also apply to telemedicine. The medical information that is transmitted electronically by my doctor to me will be encrypted during transmission and will be stored only by my doctor or a service provider selected by my doctor. I understand the dissemination of any personally-identifiable images or information from the telemedicine communication to researchers or other healthcare providers will not occur except as required by federal or California state law.

9. I understand my risks of a privacy violation increase substantially when I enter information on a public access computer, use a computer that is on a shared network, allow a computer to "autoremember" usernames and passwords, or use my work computer for personal communications. I also understand it is my responsibility to encrypt medical information I transmit electronically to my doctor and my failure to use technical safeguards, such as encryption, increases my risks of a privacy violation.

10. [I agree to be videotaped and recorded during the telemedicine services. I understand the resulting images and audio will become part of my medical record.] OR [No part of the encounter will be recorded without my written consent.]

11. I have the right to access my medical information and obtain copies of my medical records in accordance with California law.

12. I understand that the telemedicine services provided to me will be billed to my health insurance company and that I will be billed for any patient responsibility as per my insurance.

I read and understand the information provided in this Consent to Use of Telemedicine. I discussed any questions I had with my doctor and all of my questions were answered to my satisfaction.

_____ _____

Date Patient's Signature

About Telemedicine

WHAT IS TELEMEDICINE?

Telemedicine (also sometimes called telehealth) services are a way to deliver healthcare services locally to a patient when the healthcare provider is located at a distant site. Telemedicine is generally defined as the use of electronic information and communications technology to exchange medical information from one site to another site to provide medical or surgical treatment to a patient and/or to participate in the medical diagnosis of, or medical opinion or medical advice to, a patient.

When a healthcare provider believes a patient may benefit from the use of telemedicine services, telemedicine can maintain a continuity of care with the provider and facilitate patient self-management and caregiver support of the patient. Telemedicine services often provides a broader access to medical care, eliminates transportation concerns, and increases comfort and familiarity for patients and their families when located in their own homes or other local environments.

However, telemedicine uses new communications technology for which there is little research supporting its effectiveness. For example, telemedicine services may not be as complete as in-person healthcare services because the healthcare provider will not always be able to observe subtle non-verbal communications such as a patient's posture, facial expression, gestures, and tone of voice.

Telemedicine may transfer medical information through the use of interactive, real-time audio/visual technology (for example, video conferencing) or electronic data interchange (for example, computer-to-computer exchanges), or it may transfer medical information through the use of store-and-forward technology (for example, emails). While precautions are taken to secure the confidentiality of telemedicine services, the electronic transmission of medical information can be incomplete, lost or otherwise disrupted by technical failures. Additionally, despite such measures, the transmission and storage of medical information can be accessed by unauthorized persons, causing a breach of the patient's privacy.

I read and understand the information provided in this document. I discussed any question I had with my doctor and all of my questions were answered to my satisfaction.

_____ _____

Date Patient's Signature