Informed Consent for Telehealth Consultations

To better serve the needs of her patients, Dr. Fasig offers telehealth appointments (web-based audiovisual consultation), when appropriate, to patients physically present in Washington State. These appointments may assist in the evaluation, diagnosis, management and treatment of a number of health care problems. As this manner of consultation may be slightly different than that with which you are familiar, it is important that you understand and agree to the following statements.

1. I understand that Dr. Fasig will be in a different location than me during the telehealth appointment. I agree to tell Dr. Fasig my physical location at the beginning of the telehealth appointment. I understand that I need to be physically located in Washington State in order for Dr. Fasig to be able to do a telehealth consultation with me.

2. I understand Dr. Fasig may transmit or share electronically details of my medical history, examinations, x-rays, tests, photographs or other images with me via email or fax after the telehealth consultation/evaluation. Dr. Fasig will ask and confirm with me if she shares any of my medical information with other practitioners if/as needed for medical care.

3. I will be informed if any additional persons are to be present in the room with Dr. Fasig during the consultation and, if acceptable to me, verbally consent.

4. I understand Dr. Fasig will keep a record of the telehealth consultation in my medical record.

5. I voluntarily consent to health care services provided by Dr. Amy Fasig, which may include diagnostic tests, prescriptions, examinations, and medical or surgical treatments considered necessary to treat my health problem.

6. I understand that time allotted for the telehealth appointment may conclude before all my medical problems are known or treated and it is my responsibility to make arrangements for follow-up care.

7. RELEASE OF INFORMATION: Dr. Fasig is authorized to furnish medical information from my medical record to a referring physician or to any health care facility or provider to which my care may be transferred, and (3) and to any insurance company or third party payer designated by me for the purpose of the patient trying for reimbursement of the account.

8. I understand that I have the option to refuse telehealth consultation at any time without affecting the right to future care or treatment.

ASSIGNMENT OF BENEFITS and FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for all charges, including for telehealth consultation and any paid by Dr. Fasig on my behalf.

Signature of Patient or Patient's Representative:_____

Name and Date of Birth of Patient:_____

DATE:_____

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