DIGESTIVE DISEASE PHYSICIANS

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TELEMEDICINE VISIT CONSENT

I, _____, _____ attest that I was informed of the
(print name) (d.o.b)

Telemedicine visit process by the provider(s) of Digestive Disease Physicians. I have expressed interest in telemedicine visits and have granted consent to proceed with and telemedicine interview and visual exam via the HIPAA compliant platforms chosen by the practice. Telemedicine was described in detail to the patient as the use of synchronous video and audio communication to provide clinical care from a distance. Clinical medicine via a telemedicine visit can provide the same medical standard of care for specific conditions. I was informed that the practice staff located at the providers main office would assist in caring out any recommendations, clinical care and administrative formalities. It is also attested that the demographic and insurance information provided by me and/or confirmed via the staff of Digestive Disease Physicians is accurate. I understand that this telemedicine visit will be submitted to my insurance company. If my insurance plan/carrier should deny any or all charges, I then agree to be personally responsible and fully responsible for any and all balances.

_____
Signature

_____
Date