LANSDOWNE
INTERNAL MEDICINE

Consent for "Virtual" (Non-In-Person) Visits

Patient Name:_____ Date of Birth:_____

I, _____ hereby voluntarily consent to receive "virtual" care. I understand that this consent form will be valid and remain in effect for as long as I am receiving medical care at Lansdowne Internal Medicine, LLC.

Examples of the virtual services offered pursuant to this consent include:

Virtual check-ins: You and your treating provider may have a brief phone call to determine whether an in-person visit or other appropriate treatment is necessary.

E-visits: You may communicate with your treating provider through your patient portal or secure email.

TeleMed visits: You and your treating provider can use real-time interactive audio and video communication that permits real-time communication to conduct a visit while you and your treating provider are in different locations.

"Virtual" or "TeleMed visits" mean that you may be evaluated and treated by a health care provider from a distant location via electronic communication. Because this type of consultation may be different from that with which you are familiar, it is important you understand and agree to the following statements:

- My treating provider will be at a different location from me. ____ (initials)
- I understand there are potential risks associated with this technology, including, but not limited to, interruptions, unauthorized access, technical difficulties, and call termination. I understand there are limitations to this type of care and that I may seek alternative. I understand that my health care provider or I can discontinue the telemedicine visit if either party determine that the videoconferencing connection are not adequate for my situation. ____ (initials)
- I understand that I may be disconnected before all my medical problems are known or treated. It is my responsibility to make such conditions or symptoms known to the medical personnel and to make arrangements for follow-up care. ____(initials)
- I understand that Telemed visits will be billed to insurance and that copays, deductible and coinsurance may apply._____(initials)

I have read and fully understand the **Consent for "Virtual" (Non-In-Person) Visits** and agree to its contents.

Signature of Patient or Person Authorized to consent for patient:

_____ _____
Signature Date

_____
Printed Name (if other than patient)

☐ This Consent for Virtual (Not-In-Person) Visits has been provided verbally by the Patient