University Health and Wellbeing
MICHIGAN STATE UNIVERSITY

Name: _____

DOB: _____

Telehealth Consent

1. My health care provider or office staff has explained to me how the video conferencing technology will be used to engage in a telemedicine appointment and that it will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.

2. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine appointment if it is felt that the videoconferencing connections are not adequate for the situation.

3. I understand that should I choose to use data with my phone carrier, I am responsible for any fees incurred.

4. I am choosing to participate in a telemedicine appointment, and I understand that some of the normal procedures of an office visit exam may not be conducted.

5. I understand that billing will occur for these services as with any normal office visit and my insurance policy will determine whether the service is covered. I understand that it is my responsibility as the patient to verify with my insurance provider and assume responsibility for any in-network or out-of-network fees for telemedicine appointments can and will be sued towards my subsidized visits should I be both eligible for subsidized visits and have subsidized visits available for use.

6. I have had a communication with my provider or their office staff, during which I had the opportunity to ask questions regarding this telemedicine appointment process. My questions have been answered and the ricks benefits and any practical alternatives have been discussed with me in a language which I understand.

7. I understand that if I need to cancel my appointment for any reason, I need to inform Campus Health Services no later than 24 hours in advance of my appointment date/time by calling and leaving a message on the cancellation line at (517) 355-7707. I understand that if I no show for my appointment or am not available at the time scheduled time, I may be ineligible for any future telemedicine appointments.

8. As a returning patient, I have previously signed the MSU consent for Treatment and HIPAA patient responsibility Forms. I understand that I will not be in the office to sign any forms. I consent to the extension of the above forms on file.

9. If I have further questions regarding this consent or telemedicine appointments, I can email olin@msu.edu.

By signing this form, I certify that:

I have read or had this form read and/or had this form explained to me
I fully understand its contents including the risks and benefits of Telemedicine
I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction

_____ _____
Patient / Guardian Signature Date

_____
Guardian Name

_____
Relationship to Patient