eyecarecenter
A MEMBER OF Vision Source™

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Informed Consent to Telemedicine Consultation

I have been asked by my healthcare provider to take part in a telemedicine consultation with Eye Care Center and its physicians, associates, technical assistants, and others deemed necessary to assist in my medical care through a telemedicine consultation.

I understand the following:

1. The purpose is to assess and treat my medical condition.
2. The telemedicine consult is done through a two-way video link-up whereby the physician or other health provider at Eye Care Center can see my image on the screen and hear my voice. However, unlike a traditional medical consult, the physician or other health provider does not have the use of the other senses such as a touch or smell; and it may not be equal to a face-to-face visit.
3. Since the telemedicine consultants practice in a different location and do not have the opportunity to meet with me face-to-face, they must rely on information provided by me or my onsite healthcare providers. The Eye Care Center and affiliated telemedicine consultants can not be responsible for advice, recommendations and/or decisions based on incomplete or inaccurate information provided by me or others.
4. I can ask questions and seek clarification of the procedures and telemedicine technology.
5. I know there are potential risks with the use of this new technology. These include but are not limited to:
    * Interruption of the audio/video link.
    * Disconnection of the audio/video link.
    * A picture that is not clear enough to meet the needs of the consultation.
    * Electronic tampering.

   If any of these risks occur, the procedure might need to be stopped.
7. The consultation may be viewed by medical and non-medical persons for evaluation, informational, research, educational, quality, or technical purposes.
8. I understand the examination may be videotaped for internal quality review or as might be required by my health coverage plan, however the video images will only be used for those purposes unless further authorized below.
9. I will not receive any royalties or other compensation for taking part in this telemedicine consult or associated with any use by Eye Care Center.
10. FULL PAYMENT IS DUE AT THE TIME OF SERVICE. THIS INCLUDES ANY CO-PAYMENTS THAT ARE REQUIRED BY YOUR INSURANCE. Before a service is preformed, we try to contact your insurance company to receive an authorization and benefits information about your coverage. We are told by your insurance that authorization is NO guarantee of coverage. If you think we have received the wrong benefits information, please contact your insurance company or your benefit coordinator at your work. We can only use the coverage the insurance company tells us you have. If we are not a participating provider for your insurance company, full payment is required for all services. As a courtesy to our patients, we will provide the account responsible with a ledger so insurance can reimburse you. You can make your payment at https://paymeyedoc.com/eye_pay_db/pay/dobsonec.
11. I understand I can make a complaint to management at Eye Care Center.
12. I understand I can make a complaint of my provider to the Texas Optometry Board by going online at http://www.tob.state.tx.us/filing-complaint/index.html or call 512-305-8500.

I, the undersigned patient, do hereby understand and state that I agree to the above consents that I have initialed as “agree” and I do not agree to any that I have initialed as “decline.”

I certify that this form has been fully explained to me. I have read it or have had it read to me. I understand and agree to its contents. I volunteer to participate in the telemedicine examination. I authorize Eye Care Center and the doctors, nurses, and other providers involved to perform procedures that may be necessary for my current medical condition.

Date: _____ Time:_____ am/pm

Signature:_____ Printed Name:_____

Witness: _____ Interpreter (if applicable):_____