



Telehealth Informed Consent

Telehealth involves the use of secure electronic communications, information technology, or other means to enable a healthcare provider and a patient at different locations to communicate and share individual patient health information for the purpose of rendering clinical care. This “**Telehealth Informed Consent**” informs the patient (“**patient,**” “**you,**” or “**your**”) concerning the treatment methods, risks, and limitations of using a telehealth platform.

Services Provided:

Telehealth services offered by Eastern Dermatology & Pathology (“**Group**”), and the Group’s engaged providers (our “**Eric Howell, MD, FAAD**”) may include a patient consultation, diagnosis, treatment recommendation, prescription, and/or a referral to in-person care, as determined clinically appropriate (the “**Services**”).

Miiskin Group ApS does not provide the Services; it hosts and maintains the platform through which Group and our Providers provide the Services.

Electronic Transmissions:

The types of electronic transmissions that may occur using the telehealth platform include, but are not limited to:

- Appointment scheduling;
- Completion, exchange, and review of medical intake forms and other clinically relevant information (for example: health records; images; output data from medical devices; sound and video files; diagnostic and/or lab test results) between you and your Provider via:
 - asynchronous communications;
 - two-way interactive audio in combination with store-and-forward communications; and/or
 - two-way interactive audio and video interaction;
- Treatment recommendations by your Provider based upon such review and exchange of clinical information;

- Delivery of a consultation report with a diagnosis, treatment and/or prescription recommendations, as deemed clinically relevant;
- Prescription refill reminders (if applicable); and/or
- Other electronic transmissions for the purpose of rendering clinical care to you.

Expected Benefits:

- Convenient access to follow-up care. If you need to receive non-emergent follow-up care related to your treatment, please contact your Provider by calling 252-752-4124.

Service Limitations:

- The primary difference between telehealth and direct in-person service delivery is the inability to have direct, physical contact with the patient. Accordingly, some clinical needs may not be appropriate for a telehealth visit and your Provider will make that determination.
- **OUR PROVIDERS DO NOT ADDRESS MEDICAL EMERGENCIES. IF YOU BELIEVE YOU ARE EXPERIENCING A MEDICAL EMERGENCY, YOU SHOULD DIAL 9-1-1 AND/OR GO TO THE NEAREST EMERGENCY ROOM. PLEASE DO NOT ATTEMPT TO CONTACT MIISKIN GROUP APS, GROUP, OR YOUR PROVIDER. AFTER RECEIVING EMERGENCY HEALTHCARE TREATMENT, YOU SHOULD VISIT YOUR LOCAL PRIMARY CARE PROVIDER.**
- Our Providers are an addition to, and not a replacement for, your local primary care provider. Responsibility for your overall medical care should remain with your local primary care provider, if you have one, and we strongly encourage you to locate one if you do not.
- Group does not have any in-person clinic locations.

Security Measures:



Telehealth Informed Consent

The electronic communication systems we use will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption. All the Services delivered to the patient through telehealth will be delivered over a secure connection that complies with the requirements of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”).

Possible Risks:

- Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment and technologies, or provider availability.
- In the event of an inability to communicate as a result of a technological or equipment failure, please contact the Group at 252-752-4124.
- In rare events, your Provider may determine that the transmitted information is of inadequate quality, thus necessitating a rescheduled telehealth consult or an in-person meeting with your local primary care doctor.
- In very rare events, security protocols could fail, causing a breach of privacy of personal medical information.

Patient Acknowledgments:

I further acknowledge and understand the following:

1. I understand that I may be asked to provide my identification and confirm my physical location prior to or during the telehealth visit.
2. If I am experiencing a medical emergency, I will be directed to dial 9-1-1 immediately and my Provider is not able to connect me directly to any local emergency services.
3. I may elect to seek services from a medical group with in-person clinics as an alternative to receiving telehealth services from Group.
4. I have the right to withhold or withdraw my consent to the use of telehealth in the course

of my care at any time without affecting my right to future care or treatment.

5. Federal and state law requires health care providers to protect the privacy and the security of health information. I am entitled to all confidentiality protections under applicable federal and state laws. I understand all medical reports resulting from the telehealth visit are part of my medical record.
6. Group will take steps to make sure that my health information is not seen by anyone who should not see it. Telehealth may involve electronic communication of my personal health information to other health practitioners who may be located in other areas, including out of state. I consent to Group using and disclosing my health information for purposes of my treatment (e.g., prescription information) and care coordination, to receive reimbursement for the services provided to me, and for Group’s health care operations.
7. Dissemination of any patient-identifiable images or information from the telehealth visit to researchers or other educational entities will not occur without my consent unless authorized by state or federal law.
8. There is a risk of technical failures during the telehealth visit beyond the control of Group.
9. In choosing to participate in a telehealth visit, I understand that some parts of the Services involving tests (e.g., labs or bloodwork) may be conducted at another location such as a testing facility, at the direction of my Provider.
10. Persons may be present during the telehealth visit other than my Provider who will be participating in, observing, or listening to my consultation with my Provider (e.g., in order to operate the telehealth technologies). If another person is present during the telehealth visit, I will be informed of the individual’s presence and his/her role.



Telehealth Informed Consent

11. My Provider will explain my diagnosis and its evidentiary basis, and the risks and benefits of various treatment options.
12. I understand that by creating a treatment plan for me, my Provider has reviewed my medical history and clinical information and, in my Provider’s professional assessment, has made the determination that the provider is able to meet the same standard of care as if the health care services were provided in-person when using the selected telehealth technologies, including but not limited to, asynchronous store-and-forward technology.
13. I have the right to request a copy of my medical records. I can request to obtain or send a copy of my medical records to my primary care or other designated health care provider by contacting Group at: <https://easterndermatology.ema.md/ema/Login.action>. A copy will be provided to me at reasonable cost of preparation, shipping and delivery.
14. It is necessary to provide my Provider a complete, accurate, and current medical history. I understand that I can log into my “Portal” <https://easterndermatology.ema.md/ema/Login.action> at any time to access, amend, or review my health information.
15. There is no guarantee that I will be issued a prescription and that the decision of whether a prescription is appropriate will be made in the professional judgement of my Provider. If my Provider issues a prescription, I have the right to select the pharmacy of my choice.
16. There is no guarantee that I will be treated by a Group provider. My Provider reserves the right to deny care for potential misuse of the Services or for any other reason if, in the professional judgment of my Provider, the provision of the Services is not medically or ethically appropriate.

[I understand that I have a choice in receiving services by audio-only telephone, in person, or through telemedicine, to the extent clinically appropriate. I am choosing to receive my services by using audio-only telephone, but I am not prevented from receiving services in person or through telemedicine at a later date. Opportunities and limitations of delivering and receiving health care services using audio-only telephone include: My services delivered by audio-only telephone will be billed to my health insurance plan. I am financially responsible for any applicable co-payments, coinsurance, and deductibles. I understand that not all audio-only health care services are covered by all health plans.]

Patient Informed Consent

ACCEPT. By checking this Box, I acknowledge that I have carefully read, understand, and agree to the terms of this “**TELEHEALTH INFORMED CONSENT**” and consent to receive the Services. [Note – Box should not be pre-checked.]

PATIENT’S NAME:

PATIENT’S SIGNATURE:

DATE:

NAME OF MINOR PATIENT’S PARENT OR LEGAL GUARDIAN:

MINOR PATIENT’S PARENT OR LEGAL GUARDIAN’S SIGNATURE:

DATE:
