

Allergy/Asthma Specialists W. MI

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TELEMEDICINE CONSENT FORM

1. I understand that I accept my health care provider’s offer to engage in a telemedicine visit. My health care provider has explained to me how the video conferencing technology will be used to affect such a visit, which 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. Benefits of telemedicine include improved remote access to medical care by enabling a patient to remain in his/her home (or other remote site) while receiving expertise of a distant specialist in the clinic or other distant site.

3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the. In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information.

4. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation. I can terminate the consultation at any time.

5. Just like an in-office visit, I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes.

6. I have had the alternatives to a telemedicine consultation explained to me, including in-person visit either with Dr. Dubravec or other provider if indicated (like Urgent Care or Emergency Room), and I am choosing to participate in a telemedicine consultation.

7. I have had a direct conversation with my doctor, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me.

By signing this form, I certify:

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

Patient’s/parent/guardian signature Date Time

Witness signature Date Time