CONSENT TO TELEHEALTH SERVICES

This consent to participate in telehealth services with my provider, Tammy Balatgek, DDS, through a HIPAA compliant two-way audio/video link. The purpose of these services is to evaluate and treat my health condition. This care is governed by the same protections and limitations as in person care.

I understand the following:

1. The potential benefits of telehealth are increased access to care and convenience.
2. The possible risks are interruption/disconnection to the audio/video link, delay in treatment due to failure of equipment, failure of Internet connection, and the lack of access to all information that might be available in an in-person visit.
3. Dr. Tammy Balatgek will determine whether or not the condition being diagnosed or treated is appropriate for a telemedicine encounter. If telehealth services are deemed inappropriate by my provider at any time, I will be offered a different follow-up plan.
4. The telemedicine platform uses a high level of security and is HIPAA compliant. The security measures taken include encrypting all data, password protected access to data and other files. In very rare instances, security protocol could fail causing a breach of privacy or personal medical information. I agree to work with my provider to address any privacy issues or concerns where I am physically located during the evaluation, such as others in the room.
5. If I have an emergency outside of the session, I understand that I should call my provider.
6. If the connection is lost during a telehealth session, my provider will call me.
7. If I have any questions before, during, or after the visit, I may contact the main office.
8. I understand that the fee for a telehealth visit of up to 30 minutes is $80. Any supplies that are needed, such as replacement elastics or cleansers, can be shipped to me at an additional cost.

By refusing to sign this consent form, you are declining telehealth-based services only.

_____ _____
Name of Patient Date

_____ _____
Signature of Patient or Guardian Relationship to Patient

Email Address: _____

Cell Phone Number: _____

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