FDL DERMATOLOGY

medical & cosmetic dermatology

DR. COURTNEY R. HERBERT

Patient Name: _____ Date of Birth: _____

Physician Name: Dr. Courtney Herbert MD

I understand that telemedicine is the use of electronic information and communication technology by a health care provider to deliver services to an individual when he/she is located at a different site than the provider. I understand my health care provider will determine whether the condition being diagnosed and/or treated is appropriate for a telemedicine encounter. I understand I can choose to stop telemedicine consult at any time.

I understand that:

- My health care professional and I will communicate by interactive video conferencing using a telehealth platform
- My health care professional will have access to all the clinical tools available at a regular office visit (e.g. prescription refills, appointment scheduling, patient education, etc)
- There are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties
- My health care information may be shared with other individuals for scheduling and billing purposes
- The laws that protect privacy and the confidentiality of medical information also applies to telemedicine. As always, your insurance carrier will have access to your medical records for quality review/audit

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 that risk 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