CONSENT FOR CARE USING TELEHEALTH

Physicians and other medical personnel such as physician assistants (PA), Advance Practice Registered Nurses (APRN), Registered Nurses, Speech-Language Pathologists, Physical Therapists, Dietitians, Psychologists, Pharmacists, Occupational Therapists, and Social Workers are called "providers" on this form.

Instructions to patient: when this consent form is explained to you, please ask any questions you may have. If you do not understand the answers, please ask again until you do understand.

My provider has told me there could be problems using telehealth. Possible problems include:

- A telemedicine exam may not give the information needed to make a clinical decision.
- Technology problems may delay medical evaluation and treatment for the telehealth visit.
- Security measures may fail, causing a breach of privacy of personal medical information. This is very rare.
- Telehealth does not provide direct treatment, including emergency care.

For patients:

- Lack of privacy at the patient's location or because the patient may use a non-secured or shared device.
- Interruption of the visit due to local factors or technology problems

My provider has also told me about the possible benefits of the procedure. Possible benefits include:

- Improved access to care. A patient can get services from anywhere in Kentucky.
- A patient can stay close to home, working with local healthcare providers to maintain continuity of care.
- Less time and expense for travel.

I understand the provider may provide certain services using telehealth technology, including transmission of images, video and audio. I understand that these images will be used for diagnosis, treatment or consultation within Rockcastle Regional.

By signing below, I understand the following:

1. This consent is in addition to any consent I gave for the care I am receiving.
2. This consent is for all the visits that include telehealth and is valid for until you move care facilities or chose not to use telehealth.
3. I am receiving telehealth services at the location of my choice, and I assume the risks that were discussed with me.
4. I have the right to withdraw my consent to the use of telehealth in the course of my care at any time. This will not affect my right to future care or treatment.

(OVER)

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5. My provider will determine whether the condition being diagnosed or treated is appropriate for telehealth. If my provider believes I would be better served by a traditional in-person office visit, he or she may at any time stop the telehealth visit and schedule an in-person visit for certain diagnosis and treatment or in the event of a technical failure.
6. No results are guaranteed or promised by using telehealth for care.
7. I or my insurance may be billed for telehealth services. I am responsible to Rockcastle Regional Hospital for charges resulting from the services rendered using videoconferencing technology at their prevailing rates.
8. If my provider sees or hears anything that shows I have an emergency medical condition, he or she may call 911.
9. Law may require my provider to report certain events, such as self-neglect or if someone is in danger.
10. I understand that during the public health emergency caused by COVID 19, telehealth technology may be provided by a third party that does not encrypt the audio or video (for example Zoom, FaceTime and some others), and as such it may not be as secure or protected during transmission. I understand that normally telehealth technology is provided by a third party that does encrypt the audio and video (for example Doxy.me, eCW, or others), which is more secure during transmission.
11. I have been given a copy of Rockcastle Regional's Notice of Privacy Practices.

I have read this consent form, and it has been explained to me. I have received information regarding telehealth and have had the chance to ask all of the questions I have about telehealth, its alternatives, its risks, its benefits, and limitations. I have been given answers to my questions, and I understand the answers.

______________________________	______________	______________
Patient Name	Date	Time
______________________________	______________	______________
Signature of Legal Representative & Relationship to Patient	Date	Time
______________________________	______________	______________
Person obtaining consent	Date	Time