



Andrew R. Pulliam, M.D., F.A.C.S.

Board Certified

Otolaryngology - Head & Neck Surgery

Facial Plastic & Reconstructive Surgery

Patient Name: _____ Medical Record No: _____

1. I understand that my health care provider wishes me to engage in a telemedicine consultation.
2. My health care provider has explained to me how the video conferencing technology will be used to affect such a consultation and 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.
3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. 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.
4. I understand that my healthcare information may be shared with other individuals in my office for scheduling and billing purposes. A member of my staff may be present during the consultation other than my health care provider. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation.
5. I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a telemedicine consultation.
6. In an emergent consultation, I understand that the responsibility of the telemedicine consulting specialist is to seek emergency care at the local hospital emergency department.
7. I understand that billing will occur from my practitioner.
8. 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 in a language in which I understand.

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 and time:

Witness signature, date and time:
