Barr Center
for Innovative Pain &
Regenerative Therapies

Telehealth Services Consent Form

Our telehealth services are designed to provide continuity of care to our older patients and those who have a long distance to travel for routine follow up care, medication refills and post injection follow ups. During these trying times we know how important it is to stay connected to your medical providers. We are only using secure interactive videoconferencing through Zoom which is HIPPA compliant. This platform is designed to provide you the best telehealth care while ensuring privacy to protect your private health information.

1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.

2. I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room.

3. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.

    a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my healthcare provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.

4. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.

    a. I may revoke my right at any time by contacting **Barr Center for Innovative Pain & Regenerative Therapies at 757-578-2260.**

5. I understand that the laws that protect privacy and the confidentiality of healthcare information apply to telemedicine services.

6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.

    a. I understand that my insurance carrier will have access to my medical records for quality review/audit.

    b. I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurance that apply to my telemedicine visit.

    c. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.

7. I understand that this document will become a part of my medical record.

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand. During the Coronavirus pandemic we will serve patients located in the states of Virginia and North Carolina. Once this health crisis is averted, we will reassess our ability to serve our North Carolina patients using telehealth services.

_____	_____
Patient/Parent/Guardian Printed Name	Patient/Parent/Guardian Signature
_____	_____
Witness Signature	Date