Palmetto Adult and Children's Urology

2890 Tricom Street
North Charleston, SC 29406
Telephone: 843/797-6600
Fax: 843/820-1440

104-C Morgan Place
Summerville, SC 29485
Telephone: 843/879-9163
Fax: 843/879-9952

302 Medical Park, Ste 207
Walterboro, SC 29488
Telephone: 843/549-7122
Fax: 843/549-3257

Nelson R. Ploch, MD   Theodore E. Brisson, MD   S. Walker Nickles, MD   Georgia Anderson, PA-C

Patient Name:________________________________DOB:_______________________Local MRN:__________________

TELEMEDICINE PROGRAM

TELEMEDICINE PATIENT CONSENT FORM

I, (name of patient or parent/guardian) _________________________, agree to participate in a telemedicine evaluation. By signing this agreement, I authorize the electronic transmission of my medical information and/or videoconference session so that it can be viewed by a doctor and other persons involved in my medical care. [**Note:** The likelihood of this transmission being intercepted by persons other than those at the consulting site is extremely small].

I understand that I can withdraw my permission at any time and that I do not have to answer any questions that I consider to be inappropriate or am unwilling to have heard by other persons. I understand that if I do not choose to participate in a telemedicine session, no action will be taken against me that will cause a delay in my care and that I may still pursue face-to-face office consultation.

I understand that as with any technology, telemedicine does have its limitations. There is no guarantee, therefore, that this telemedicine session will eliminate the need for me to see a specialist in person.

I understand that a telemedicine visit is charged to my insurance company and I am responsible for any copay/deductible/coinsurance. I authorize payment of medical benefits to the physicians of Palmetto Adult and Children's Urology, PA for services rendered including telemedicine.

I agree to have my telemedicine medical records reviewed for the purposes of evaluation (data collection, analysis and presentation in verbal or written format at scientific meetings). I understand that any presentation will not identify me by name or other identifiable markers. **DECLINE________(initials of patient)**

If clinical information regarding HIV status is included in my medical record for purposes of the telemedicine evaluation, I agree to the collection of these data for research purposes. **DECLINE________(initials of patient)**

Signature of patient (or parent/guardian):____Date: _______________

Please print the above name: ____

Signature of witness:____Date: _______________

➲ *For withdrawal from a telemedicine evaluation, please complete the information on the back of this page*

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❒ **(MARK THIS BOX AND SIGN BELOW FOR WITHDRAWAL ONLY).** I have chosen not to participate further in this telemedicine evaluation.

Signature of patient (or parent/guardian):____Date: _____________

Signature of witness: ____