Northwest Women's Clinic
Obstetrics & Gynecology

Roberto M. deCastro, MD
Robin W. Barrett, MD
Michael W. Davis, MD
Physicians & Surgeons

Rebecca A. Kyle, DO
Kelley E. Burkett, MD
Saramati J. Krishna, MD
Physicians & Surgeons

Holly Spence, CNM
Lydia Hammond, CNM
Certified Nurse Midwives

Juliana Baron, CNM
Alina Palmer, CNM
Certified Nurse Midwives

Telemedicine Consent

Patient name_____ DOB_____
Chart#_____

1. I understand that my health care provider wishes to engage in a telemedicine appointment.
2. My health care provider and/or their staff has explained to me how video conferencing technology will be used in such a consultation. I understand this is can not be the same as direct patient/provider visits due to the fact that I will not be in the same room as the provider.
3. I understand that should I choose to use data with my phone carrier, I am responsible for any accrued charges.
4. I understand that there are potential risks to this technology including interruptions, unauthorized access, and technical difficulties. I understand that both my provider or I can discontinue the telemedicine visit if it is felt that the technology is not adequate for the situation.
5. I understand that my health care information may be shared with other individuals for scheduling and billing purposes. There may also be other support staff present to assist the provider with the telemedicine visit. All individuals within the provider's office will operate within all HIPAA compliance rules and regulations.
6. I have had the alternatives to telemedicine visits explained to me and am choosing to participate in this appointment type. I understand that some of the normal procedures of an office visit may not be conducted.
7. I understand that billing will occur for these services as with any normal office visit, and my insurance policy will determine whether the service is covered. I understand that I will be responsible for any charges and/or balances that insurance doesn't cover.

By signing this form, I certify;

*That I have read or had this form read and/or explained to me.
*That I fully understand its contents including the risks and benefits of Telemedicine
*That I have been given ample opportunity to ask questions and they have been answered to my satisfaction.

_____ _____
Patient/parent/caregiver signature Date

2222 NW Lovejoy, Suite 619 Portland, OR 97210 (503) 416-9922 Fax (503) 416-9971
11750 SW Barnes Road, Suite 300 Portland, OR 97225 (503) 416-9922 Fax (503) 416-9971