Informed Consent for Telemedicine Services

Patient Name:_________________________________ Birthdate: _______________________

Introduction

Kidney Specialists of Minnesota, P.A. ("KSM") is utilizing all available resources to meet patient needs in an effort to maintain the health of its patients and staff as a result of the COVID-19 Pandemic. As part of its efforts, KSM will be using telemedicine and other technologies to maintain contact and provide services to its patient whenever feasible subject to client consent. Telemedicine involves the use of electronic communications to enable KSM care providers to provide services to you through cellphones, handheld devices or computers.

Expected Benefits: The expected benefits of using telemedicine for patients include:

- Reduced risk of exposure to COVID-19 for care providers as well as patients; and
- Increased opportunity for communication with care providers and monitoring of patients through the COVID-19 Pandemic.

Possible Risks: As with any process, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g., poor resolution of images) to allow for appropriate medical decision-making by the physician and/or other health care practitioners;
- In rare cases, because the treating practitioner may not have access to information that would be apparent or available in a face-to-face visit, the use of telemedicine may result in errors in medical judgment;
- Delays in services could occur due to deficiencies or failures of the equipment;
- Using telehealth services involves some risk that an unauthorized person may see, access, copy, or interrupt my personal information. There is some risk unencrypted electronic communications could be intercepted in transmission or misdirected to a third party not authorized to receive the information.

Understanding: I acknowledge that:

1. I am responsible for the security of my connection needed to receive telemedicine services.
2. I understand that telemedicine may involve electronic communication of my personal health information over communication lines that may not be secure.
3. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine by sending a written communication stating my withdrawal by e-mail to KSM at patientcare@ksmclinics.com, however my participation in telemedicine services includes my implied consent to telemedicine services.
4. I understand my health benefits plan may not cover telehealth services and I may need to pay for telehealth visits, including copayments, co-insurance, or deductibles. I understand I am encouraged to discuss my telehealth service coverage with my health benefits plan.

Consent: I have read and understand the information provided above regarding telemedicine and understand the risks and benefits. I hereby give my informed consent and authorize ***KSM and its providers*** to use telemedicine in the course of my care.

Electronic Signature: I understand that I can sign this form by typing my name below and returning it electronically. I agree that a copy is as effective as an original.

Signature of Client (or person authorized to sign for patient):

____ *Date:*_____________________

*If authorized signer, relationship to Client:*________________________________ *Date:*_______________