**Metroplex Pulmonary & Sleep Center 1701 Eldorado Pkwy, Ste 250, McKinney, TX 75069 Ph: 972-838-1892**

**Informed Consent for Telehealth Services (Televisit)**

**Patient Name: _____ Date: _____**

I, the undersigned patient (or legally authorized representative), understand and agree to the following regarding the use of telehealth for my medical care:

**Nature of Telehealth Services**

- **Description:** I will be receiving medical services through a two-way, real-time interactive audio and video link, or other electronic media, with a healthcare provider who may be at a distant location.
- **Limitations:** I understand that some parts of a physical examination may not be possible, and the provider will be relying on information I provide. The service may not be equivalent to an in-person, "hands-on" visit.
- **Alternatives:** I have the right to choose an in-person visit with a medical professional as an alternative to receiving telehealth services.

**Risks and Benefits**

- **Potential Benefits:** These may include increased access to care, specialist consultations, and convenience.
- **Potential Risks:** These may include, but are not limited to, the possibility of technological failure, interruption or disconnection of the audio/video link, a picture that is not clear enough for a proper evaluation, or a breach of confidentiality despite security measures.
- **Emergencies:** I understand that if I am experiencing a medical emergency, I must dial 9-1-1 immediately and that my provider cannot connect me directly to emergency services.

**Confidentiality and Information Sharing**

- **Privacy:** My health information is protected by federal and state laws and is part of my medical record.
- **Disclosure:** While efforts are made to ensure privacy, the security of electronic transmission cannot be absolutely guaranteed. I will be informed if others are present during the visit.
- **Primary Care Provider Notification:** With my consent, my provider may share a report of the visit with my primary care physician.

**Patient Rights and Responsibilities**

- **Right to Refuse/Withdraw Consent:** I can choose to stop using telehealth at any time without affecting my future care.
- **Provider Discretion:** My provider can decide to stop the telehealth session and recommend an in-person visit if needed.
- **Complaints:** I can contact the Texas Medical Board to file a complaint by calling 1-800-201-9353 or visiting their website.

**Attestation**

By signing below, I confirm I have read and understand this form, have had my questions answered, and agree to receive telehealth services. I also confirm I am in Texas.

**Patient/Legally Authorized Representative Signature:** _____
**Printed Name:** _____ **Date:** _____
**Relationship to Patient (if applicable):** _____