YOASH R. ENZER, MD, FACS
Cosmetic, Laser, and Oculofacial Plastic Surgery
ASHLEY L. WRIGHT, FNP
Aesthetic Nurse Practitioner
120 Dudley Street, Suite 104 | Providence, RI 02905
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Patient Name: ____ **Date:** ____________________

Telemedicine Patient Consent Form

Telemedicine is a mode of delivering healthcare services and public health utilizing information and communication technologies to enable the diagnosis, consultation, treatment, education, care management, and self-management of patients at a distance from health care providers.
For further details visit: https://health.ri.gov/healthcare/about/telemedicine/

1. **PURPOSE:** The purpose of this form is to obtain your consent to participate in a telemedicine consultation to discuss symptoms in real-time for health insurance covered medical issues and/or cosmetic concerns, treatment options, and prescriptions if warranted.
2. **NATURE OF TELEMEDICINE CONSULT:** During the telemedicine consultation:
   a. Details of your medical history, examinations, x-rays, and tests will be discussed with you, and any other people you invite, and possibly including other health professionals using interactive video (FaceTime, Skype, Zoom, or private HIPPA-compliant telemedicine platforms) audio, and telecommunication technology.
   b. A physical examination of you may take place.
   c. A non-medical technician may be present in the telemedicine studio to aid in the audio or video transmission. Medical assistants from our office may also participate.
   d. Video, audio and/or photo recordings may be taken during the procedure(s) or service(s).
3. **MEDICAL INFORMATION & RECORDS:** All existing laws regarding your access to medical information and copies of your medical records apply to this telemedicine consultation. Please note, not all telecommunications are recorded and stored. Additionally, dissemination of any patient-identifiable images or information for this telemedicine interaction to researchers or other entities shall not occur without your consent.
4. **CONFIDENTIALITY:** Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation, and all existing confidentiality protections under federal and Rhode Island state law apply to information disclosed during telemedicine consultation.
5. **RIGHTS:** You may withhold or withdraw consent to the telemedicine consultation at any time without affecting your right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.
6. **DISPUTES:** You agree that any dispute arriving from the telemedicine consult will be resolved in Rhode Island, and that Rhode Island law shall apply to all disputes.
7. **RISKS, CONSEQUENCES & BENEFITS:** You have been advised of all the potential risks, consequences and benefits of telemedicine (HIPPA and the HITECH act). Your health care practitioner has discussed with you the information provided above. You have had the opportunity to ask questions about the information presented on the form and the telemedicine consultation. All your questions have been answered, and you understand the written information provided above.

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8. **RESOURCES NEEDED TO PARTICIPATE**: In order to participate in telemedicine, you will need to be able to do the following:
   a. Download the appropriate *new patient forms* (cosmetic or medical) from our website, complete, and send back (email, fax, mail) to our office before your virtual appointment.
      1. Attach a copy of your photo ID and insurance card(s) with your new patient forms.
   b. Access a smart phone with video capability, IPAD, or a computer with web cam and microphone.
   c. Video platform: FaceTime, Skype, Zoom, or our private HIPPA-compliant telemedicine platform.

I have read and fully understand the above statements. I agree to participate in telemedicine consultations.

____ ____________________

Patient Signature **Date**

____ ____________________

Physician Signature **Date**