Island Rheumatology and Osteoporosis, PC
6144 Route 25A Building C, Suite 13
Wading River, NY 11792
Phone: 631-886-2844 / Fax: 631-886-2842

Telemedicine Consultation Service Policy

Patient Full Name: _____Date of Birth: _____

1. I understand that my health care providers at "Island Rheumatology and Osteoporosis, PC" offer and would like me to engage in a telemedicine consultation.
2. My health care provider has explained to me how the video conferencing technology will be used with "DOXY.ME" however, will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.
3. I understand that some parts of the exam involving physical tests may not be conducted or with help of individuals at my location (another providers office, health aide, or family members assistance) at the discretion of my consulting health care provider.
4. I have been made aware of the many benefits of telemedicine consultation including, but not limited to, continuity of care, refill or change in prescription medication(s), being at a safe location in times of crisis or natural disasters, unsafe weather conditions, address my questions and concerns about my health and more.
5. I agree to follow any urgent requests made by my provider which may affect my health and overall being. Such as obtaining critical lab or imaging requests to improve my health. Also, if needed, going to the emergency room or urgent care or seeking other specialists.
6. I understand there are many benefits to this technology, however. technical difficulties: including interruptions, unauthorized access and others can occur. Furthermore, that my healthcare provider or I can discontinue/end the telemedicine consult/visit if it is felt that the video-conferencing connections are not adequate for the situation.
7. I understand that my provider will bill and collect claims for the services rendered, including office co-payments. If any payments are received to me from my insurance carrier, I will forward those payments endorsed to "Island Rheumatology and Osteoporosis, PC"
8. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes.
9. I understand that other personnel may also be present during the consultation, besides my health care provider team/office, in order to operate the video equipment. All mentioned people will all maintain confidentiality of the information obtained. In that situation, I am aware that I have the following rights:
    a. Requesting to omit specific details of my medical history/physical examination that are personally sensitive to me.
    b. Ask non-medical personnel to leave the telemedicine examination room.
    c. Terminate the consultation at any time.

My questions have been answered thoroughly including the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

By signing this form, I certify that I have read this policy on Telemedicine Services rendered by my provider and I am in agreement to participate in telemedicine consultation(s).

Signature: _____ **Date**: _____