Tele-Visit Consent:

I have requested to take part in a telemedicine consultation with Mays Dermatology and its physicians, associates, technical assistants and others deemed necessary to assist in my medical care through a telemedicine consultation.

I understand the following:

The purpose is to asses and treat my medical condition. The telemedicine consult is performed through a two-way video link whereby the physician or other health provider at Mays Dermatology can see my image on the screen and hear my voice. Alternatively the office may need photos. Unlike a traditional medical consult, the physician does not have the use of the other senses such as touch or smell, nor able to thoroughly view my skin concerns in person. I understand there are potential risks of misdiagnosis and delayed treatment in this setting due to its limitations. I also understand that Mays Dermatology staff must rely on information provided by me or my onsite healthcare providers. I know there are potential risks with the use of this new technology including disconnection of the audio/video, an unclear picture that does not meet the needs of the consultation, and/or electronic tampering.

If you are using your insurance for your telemedicine visit, a $80 deposit, or your co-pay/deductible will be collected at the time your appointment is made, whichever is HIGHER.

Patients with 100% MEDICARE ONLY (not replacement plans) will not require a deposit. If you are currently self pay or do not choose to use your insurance, an $80 flat fee will be collected for your visit.
If the telemedicine visit is covered by your insurance and your deposit amount is higher than the amount allowed by the insurance company for your visit, the difference between the copay and deposit will be refunded using the original method of payment upon receipt of your EOB from your insurance company. Otherwise this fee is non-refundable. If you require an in person visit for additional procedures such as biopsy, freeze, or injection there may be additional charges as per your insurance coverage.

I, the undersigned patient, do hereby understand and state that I agree to the above terms. I certify that this form has been fully explained to me. I have read it or have had it read to me. I understand and agree to its contents. I volunteer to participate in the telemedicine examination performed by Mays Dermatology. This consent will stay on file and apply to all my tele-visit appointments until one calendar year from date of signature.

_____ **Patient Signature**

_____ Patient Name (print)

Date: _____/_____ / _____