Tele-Visit Consent:

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

I understand the following:

The purpose is to assess 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 and speak with you via phone only. 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.

I understand that Mays Dermatology & Cosmetic Center will not bill any insurance company for my Telemedicine visit.

New Patient Tele-visit: $125
Established Patient Tele-Visit: $85

If you require an in person visit for additional procedures such as a biopsy, freezing, or injection there may be additional charges which will be relayed to you during your visit.

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: _____/_____ / ______