



Telehealth- Patient Consent Form

Patient Name: _____

Date of Birth: _____

I understand that telemedicine is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to the providers at Family Physicians of Laramie providing health care services to me via telemedicine.

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine. As always, your insurance carrier will have access to your medical records for quality review/audit.

I understand that I will be responsible for any copayments or coinsurances that apply to my telemedicine visit. The payment policy as set forth in the FINANCIAL AGREEMENT/ PAYMENT POLICY/ AUTHORIZATION FOR TREATMENT consent form will pertain to all telehealth visits.

I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting the office of Family Physicians of Laramie at 307-742-3242. As long as this consent is in force (has not been revoked) Family Physicians of Laramie may provide health care services to me via telemedicine without the need for me to sign another consent form.

I consent that I meet all the terms and conditions listed above

Signature of patient (or guardian)

Date

Family Physicians of Laramie, LLC.

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