7585 Clarington Cove
Southaven, MS 38671
P (662) 349-0200
F (662)349-1666

Terri H. Henson, MD
Misty Moore, MSN, ARNP, BC
C. Danielle Thomas, PA-C

CONSENT TO TELEHEALTH VISIT

1. Purpose.

The purpose of this form is to get your consent for a telehealth visit with our dermatologist (expert skin doctor, hereinafter referred to as "PROVIDER(S)") and dermatology physician extenders (dermatology trained nurse practitioners or physician assistants, also hereinafter referred to as "PROVIDER(S)") at Dermatology Clinic of N MS, PLLC. The purpose of this visit is to help in the care of your skin problem.

2. How Telehealth Works.

In a telehealth visit, you will interact with your provider through submission of a photo and chief complaint via secured electronic messaging. The photo(s) must be current (taken within 48 hours of submission of your virtual visit), taken in good lighting, and taken without a filter such as those provided by SnapChat. The provider will review the photos you submitted and will then give you advice about your dermatologic condition and how to treat and take care of your condition.

3. Pros, Cons and Your Options.

- As with any telemedicine visit, the provider's advice will be solely based on viewing your skin condition from the information and images provided by you electronically. In the absence of an in-person physical evaluation, the provider may not be aware of certain facts that may limit or affect his or her assessment or diagnosis of your condition and recommended treatment. It is possible that there will be errors or deficiencies in the transmission of the images of your skin condition in the photos submitted electronically that may impede the provider's ability to advise you about your condition.
- It is possible a face-to-face follow-up visit with the provider may still be required. This can depend on a variety of factors including but not limited to issues with images transmitted, treatment plan compliance, drastic change in treatment plan requiring more in-depth discussion, report of potential serious side effects by patient, etc.
- Also, very rarely, security measures can fail to protect your personal information. The company that is providing the technology for your telehealth visit has extensive security measures in place to prevent such failures from happening and our office maintains HIPAA compliance for all electronic communication. However, breeches of electronic medical records are always a potential threat despite the best and most up-to-date security measures.

4. Medical Information and Records.

All federal and state laws covering access to your medical records (and copies of medical records) also apply to telehealth. No one other than your provider and the office staff necessary to facilitate your visit (medical assistants, nurses, etc) can view your photos or medical information unless you agree to give them access.

5. Privacy.
All information given at your telehealth visit will be maintained by our office and will be protected by federal and state privacy laws.

6. Your Rights.
You may opt out of the telehealth visit at any time. This will not change your right to future care or health benefits.

7. Waiver/Release.
By signing below, you understand and agree that you solely assume the risk of any errors or deficiencies in the electronic submission of your images to your provider and further understand that no warranty or guarantee has been made to you concerning any particular result related to your condition or diagnosis. To the extent permitted by law, you also agree to waive and release your provider and his or her practice from any claims you may have about this advice or the telehealth visit generally. The consent provided in this document will expire in one year from the date you sign it, but your waiver and release shall apply indefinitely for any telehealth visits that occur during the one-year period after your signature date.

My provider has talked with me about the telehealth visit. I have had the chance to ask questions and all of my questions have been answered. I have read this form, understand the risks and benefits of the telehealth visit, and agree to a telehealth visit under the terms explained above.

______________________________		______________________________
Signature of Patient	or	Signature of Patient's Representative
______________________________		______________________________
Name of Interpreter / ID #		Relationship of Representative to Patient
______________________________		______________________________
Signature of Witness Date of Signing *(required if patient is unable to sign)*		Date of Signing