Atlanta Women's
OBSTETRICS & GYNECOLOGY, PC

INFORMED CONSENT FOR TELEMEDICINE

Telemedicine visits at Atlanta Women's Obstetrics & Gynecology, PC involve a videoconferencing application, doxy.me, to allow our physicians to deliver the same great care without requiring the patient to come into the office. As a patient, it is important that you acknowledge and understand the following:

- The same standard of care applies to a telemedicine visit that applies to an in-person visit/consultation.
- This consent is for your health care provider only. There will be no other individuals in the room with your provider during your telemedicine visit.
- There are potential risks when using technology to deliver care, including service interruptions, interception, and technical difficulties. It is not likely, but it is possible that your appointment may be discontinued, delayed, or rescheduled due to technical issues.
- You have the right to refuse to participate or discontinue participation in a telemedicine visit. Your refusal does not affect your right to future care or treatment.
- The same laws that protect your privacy and the confidentiality of your health care information apply to telemedicine services.
- Your information will be shared with pertinent staff for billing and scheduling purposes.
- If applicable, your insurance carrier will have access to any medical records pertaining to this telemedicine visit for billing purposes. You will be responsible for any out-of-pocket costs associated with your telemedicine visit.
- Documentation of your telemedicine visit(s) will become a part of your medical record.

By signing this form, or giving a verbal confirmation to your physician, you attest that: (1) you have read the information in its entirety and fully understand and agree to its contents, (2) you have been given the opportunity to ask questions and all questions have been answered in a satisfactory manner, and that (3) you are located in Georgia (USA) and will be in Georgia during your telemedicine visit.

I have read and understand the all of the information presented above. I understand my rights and accept responsibilities outlined in this document.

_____ _____

Patient Signature **Date**

Atlanta Women's
Obstetrics & Gynecology, PC

275 Collier Road NW
Suite 230
Atlanta, GA 30309

(404) 352-3616
www.awog.org