UT Southwestern
Medical Center

Telemedicine Consent

Pt. Name:_____

Address:_____

_____

City State Zip

MRN: _____

DOB: _____ SEX: _____

I. Introduction. Telemedicine involves the real-time evaluation, diagnosis, consultation on, and treatment of a health condition using advanced telecommunications technology, which may include the use of interactive audio, video or other electronic media. As such, telemedicine allows the provider to see and communicate with the patient in real-time.

I understand that to receive telemedicine services I will need to be physically located in the State of Texas at the time of the appointment. If I am unable to be physically located in the State of Texas at the time of the appointment, I understand I will need to reschedule my appointment with my UT Southwestern Telemedicine Providers.

II. Consent for Treatment. I voluntarily request UT Southwestern physician(s) and such other faculty physicians, fellows, trainees, associates, advanced practice providers, technical assistant and other health care providers as they deem necessary ("UT Southwestern Telemedicine Providers") to participate in my medical care through the use of telemedicine.

I understand that UT Southwestern Telemedicine Providers (i) may practice in a different location than where I present for medical care, (ii) may not have the opportunity to perform an in-person physical examination, and (iii) rely on information provided by me. I acknowledge that UT Southwestern Telemedicine Providers' advice, recommendations, and/or decision may be based on factors not within their control, such as incomplete or inaccurate data provided by me or distortions of diagnostic images or specimens that may result from electronic transmissions. I acknowledge that it is my responsibility to provide information about my medical history, condition, and care that is complete and accurate to the best of my ability. I understand that the practice of medicine is not an exact science and that no warranties or guarantees are made to me as to result or cure.

If UT Southwestern Telemedicine Providers determine that the telemedicine services do not adequately address my medical needs, they may require an in-person medical evaluation. If I experience an urgent matter, such as bad reaction to any treatment after a telemedicine session, I should alert my treatment team.

III. Release of Information. To facilitate the provision of care and/or treatment through telemedicine, I voluntarily request and authorize the disclosure of all and any part of my medical record (including oral information) to UT Southwestern Telemedicine Providers. I understand and agree that the information I am authorizing to be released may include: 1) AIDS/HIV test results, diagnosis, treatment and related information; 2) drug screen results and information about drug and alcohol use and treatment; and 3) mental health information; and 4) genetic information.

I understand that the disclosure of my medical information to UT Southwestern Telemedicine Providers, including the audio and/ or video, will be by electronic transmission. Although precautions are taken to protect the confidentiality of this information by preventing unauthorized review, I understand that electronic transmission of data, video images, and audio is new and developingtechnology and that confidentiality may be compromised by failures of security safeguards or illegal and improper tampering.

I certify that this form has been fully explained to me, that I have read it or have had it read to me, and that I understand its contents.

_____ _____ _____

Patient's Signature Time Date

_____

Patient's Printed Name

_____ _____ _____

Legal Representative's Signature Time Date

_____

Legal Representative's Printed Name*

*If signing as the legal representative, I represent to UT Southwestern that I am the legal representative of the patient and agree to provide proof of legal representation, if requested. Should my legal authority terminate, I agree to provide written notification to UT Southwestern.

_____ _____ _____

Interpreter's Signature Time Date

_____

Interpreter's Printed Name

CONS TELE

UT Southwestern
Medical Center

PATIENT COMPLAINT PROCEDURE

While we hope every patient's visit goes smoothly, it is important that we are notified of patient concerns so we can take the appropriate steps to address them.

A patient has the right to communicate a verbal or written complaint or concern regarding any aspect of his/her visit (i.e. medical care, service, conditions, billing) and expect a timely response. If you have comments, questions or concerns, we recommend that you or your representative:

- Discuss them with your immediate caregiver, or
- Speak to the manager of the clinic or service in which you are receiving care, or
- If you believe your questions or concerns have not been adequately addressed, you may request a review by contacting the Patient Assistance Office. Grievance forms are available from Guest and Patient Relations or the Patient Assistance Office should you wish to use one. You may also contact the Patient Assistance Office by phone at 214-648-0500, by email at **patientassistanceoffice@utsouthwestern.edu**, or in writing at the address below:

Patient Assistance Office
UT Southwestern Medical Center
5323 Harry Hines Blvd.
Dallas, TX 75390-8831
214-648-0500

NOTICE CONCERNING COMPLAINTS

Complaints regarding quality of care at a Joint Commission-accredited health care organization may be reported for investigation at the following address:

The Joint Commission, Office of Quality Monitoring
One Renaissance Boulevard
Oakbrook Terrace, IL 60181

Assistance in filing a complaint with The Joint Commission is available by calling toll-free: **1-800-994-6610**.

Complaints about physicians, as well as other licensees and registrants of the Texas Medical Board, including physician assistants, acupuncturists, and surgical assistants may be reported for investigation at the following address:

Texas Medical Board
Attention: Investigations
333 Guadalupe, Tower 3, Suite 610
P.O. Box 2018, MC-263
Austin, TX 78768-2018

Assistance in filing a complaint is available by calling the following telephone number: **1-800-201-9353**.

For more information please visit their website at www.tmb.state.tx.us

If you are with a health maintenance organization and wish to file a complaint, you may do so by contacting the Texas Department of Insurance at 1-800-252-3439.

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CONSENT FOR ADMISSION / TREATMENT

Location of treatment:

☐ UT Southwestern University Hospital ☐ Outpatient Surgery Center

☐ Outpatient Clinic _____(clinic name)

1. **APPLICATION FOR ADMISSION AND CONSENT FOR TREATMENT:**
I voluntarily consent to the procedures and services that may be performed for me on an inpatient or outpatient basis under the general and special instructions of my physician, and/or his/her assistant or designee. I understand that these procedures and services may include but are not limited to emergency treatment or services, laboratory procedures, imaging services, medical or surgical treatment or procedures, anesthesia or hospital services. I understand that other conditions may be diagnosed which may require additional treatment. I authorize and consent to use of recordings, films, or other images of me (i.e., any photographic, video, electronic or audio media) for purposes of identification, diagnosis, treatment, education, or quality improvement in connection with the care provided to me. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as to the result of any treatment or examinations provided by UT Southwestern. I acknowledge that any supplies, medical devices or other goods sold or given to me are provided "as is", and that UT Southwestern disclaims any express or implied warranties related thereto.
2. **AGREEMENTS AND UNDERSTANDINGS:**
   a. I have the right to consent, or refuse to consent, to any proposed procedures or therapeutic courses of treatment.
   b. I understand that the physicians participating in my care, including my physician, may be either employees of UT Southwestern or independent contractors who are not employees or agents of UT Southwestern. I understand that the physicians participating in my care have been granted the privilege of using UT Southwestern facilities for the care and treatment of their patients or are licensed practitioners participating in the care of patients as part of a post-graduate medical education program. As a teaching institution, UT Southwestern welcomes medical residents and students in other disciplines, including nursing and University approved observers engaged in an educational purpose, all of whom are under the direct supervision of a privileged provider or staff member.
   c. I understand that regardless of my assigned insurance benefits, **I AM RESPONSIBLE FOR AND DO HEREBY EXPRESSLY ASSUME FINANCIAL RESPONSIBILITY FOR** the total charges for hospital, physician, medical and other services rendered. I will receive separate bills for physician professional fees and services rendered by outside agencies.
   d. I understand that UT Southwestern has the right to pursue full collection efforts including asset credit checks and litigation.
   e. I acknowledge that this consent includes all outpatient care rendered with the same diagnosis and treatment, and that UT Southwestern need not obtain another consent for outpatient care with the same diagnosis or treatment unless I revoke this consent in writing.
   f. By providing a wireless or landline telephone number the patient and/or guarantor consents to receiving auto-dialed and pre recorded voice and text messages from UTSW and its third party debt collectors at that number. The patient and/or guarantor may revoke this consent to receive voice and text messages at anytime.
3. **RELEASE OF INFORMATION:**
   a. I understand that as part of my health care, UT Southwestern personnel and my physician create and maintain a record of the care and services provided. I also understand that such information may be used and/or disclosed in the management and delivery of care and services provided by UT Southwestern to me, as described in the Notice of Privacy Practices.
   b. I understand and acknowledge that UT Southwestern participates in an electronic medical record exchange program with other health care facilities and providers ("Exchange Participants"). I understand that when I seek treatment from UT Southwestern or Exchange Participants, my health information may be shared electronically between UT Southwestern and Exchange Participants in order to provide care and services to me, and I do hereby authorize UT Southwestern to share my health information in this manner with Exchange Participants. I also understand that my health information may include certain "Sensitive Information" such as genetic information and diagnoses or treatments for substance abuse, mental illness (excluding psychological notes) or communicable diseases (including HIV or AIDS), and that some Sensitive Information cannot be disclosed through the medical record exchange program without a separate authorization by me.
   c. I understand and acknowledge that as part of receiving my health care at UT Southwestern, my physician and other personnel engaged in my care may electronically request my prescription medication history from participating pharmacies, pharmacy benefit managers, or payers, and that such prescription medication history may become part of my medical record.
4. **ASSIGNMENT OF BENEFITS AND FINANCIAL AGREEMENTS:**
I hereby assign to UT Southwestern, and any practitioner providing care and treatment to me, any and all benefits and all interest and rights for services rendered under any insurance policies, including but not limited to Medicare, Medicaid, Tricare, or any reimbursement from a pre-paid health care plan. This means that UT Southwestern and other practitioners will be entitled to directly receive all insurance payments on my behalf. If my treatment was caused by events which result in legal action, I assign to UT Southwestern any interest in any claims I may have to the extent necessary to fully reimburse UT Southwestern for the rendering of services to me. I understand and agree that my account is due in full upon discharge, with allowance made for insurance coverage approved and verified prior to discharge.
5. **VALUABLES:** I understand that UT Southwestern does not assume the responsibility for the safekeeping of any personal property that I choose to keep on my person or in my hospital room during my stay, such as, but not limited to money, jewelry, eyeglasses, dentures or hearing aids.
6. **NOTICE OF PRIVACY PRACTICES:** I acknowledge that I received a Notice of Privacy Practices as part of this visit/admission or during a previous visit/admission. I understand that a copy of the Notice of Privacy Practice is available to me at any time upon my request.
7. **PATIENT RIGHTS AND RESPONSIBILITIES:** UT Southwestern acknowledges that I have certain rights as a patient, and I acknowledge I have certain responsibilities as a patient. This information (including how to register complaints I may have) is posted throughout the hospital and a written copy was given to me upon admission.
8. **TO BE COMPLETED FOR PATIENTS SEEN AT UT SOUTHWESTERN UNIVERSITY HOSPITALS, OUTPATIENT SURGERY CENTER, AND HOSPITAL-BASED CLINICS.**

a. I have a Medical Power of Attorney.	_____Yes _____No	Copy provided?	_____Yes _____No
I have a Mental Health Directive.	_____Yes _____No	Copy provided?	_____Yes _____No
I have executed an Advance Directive.	_____Yes _____No	Copy provided?	_____Yes _____No
b. I have received information about Advance Directives as required by federal law.			_____Yes _____No
c. Would you like to discuss Advance Directives with a hospital staff member?			_____Yes _____No

I understand it is my responsibility to provide a copy of these documents to UT Southwestern.

9. **RECORDING PROHIBITED**: I understand that UT Southwestern policy prohibits patients and visitors from using personal devices to take photographs, video, audio, or other recording of any procedure, service, treatment or medical records. This prohibition includes recording and sharing of any kind, such as social media, live streaming, and real time applications (e.g., SnapChat, FaceTime, Skype).

I have read the above document and understand its contents. I acknowledge that I am the patient or I am the patient's legally authorized representative, and/or guarantor and consent to the above items and make the acknowledgments hereby made.

Signature of Patient/Responsible Party (Relationship to Patient)	Time AM/PM	Date
UT Southwestern Representative	Time AM/PM	Date
Signature and Printed Name of Interpreter or Language Line Interpreter ID#	Time AM/PM	Date

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