The Office of Leila Rhodes M.D.

Telehealth Terms of Use

Visit Date	Last Name	First Name	MI	Date of Birth	Phone Number

Important Information About Your Use of the Service

Telehealth Services ("Service") provides evaluation, diagnosis, consultation, and treatment using an interactive audio and video telecommunications system that permits real-time communication between you and your provider.

DO NOT USE THIS SITE FOR EMERGENCY MEDICAL NEEDS.

If you experience a medical emergency, call 911 immediately.

You acknowledge that your ability to access and use the Service is conditional upon the truthfulness of this certification and that the Providers you access are relying upon this certification in order to interact with you. In the event that your certification is inaccurate, you agree to indemnify the healthcare providers you interact with from any resulting damages, costs, or claims.

I Understand:

- Telehealth visits are clinical visits, rules and confidentiality apply.
- I have the right to withhold or withdraw my consent for the use of Telehealth at any time, without affecting my right to future care or treatment.
- If I am a parent/legal guardian engaging Telehealth Services on behalf of a minor child or person who lacks capacity to provide consent, I will consent and be present for the visit and I further understand that special circumstances may apply.
- I will be informed of the clinical staff, involved in my case, present during my Telehealth Service.
- The laws that protect privacy and the confidentiality of medical information also apply to Telehealth, and that no information obtained in the use of Telehealth which identifies me will be disclosed to researchers or other entities without my consent.
- I have the right to request copies of my health information, including records of my Telehealth visit, and receive copies of this information, in accordance with applicable federal and state laws, for a reasonable fee.
- My insurance carrier may have access to my medical records for payment and/or quality assurance.
- My insurance may be billed for the Telehealth Service and that I will be responsible for the copay, co-insurance, deductible, and other patient responsibility.
- My health information may be shared by my Providers with other medical providers, who may be located in other areas including out of state, by electronic or other means, in order to improve my medical care.
- My Provider will determine whether or not the condition being diagnosed and/or treated is appropriate for a Telehealth encounter via the Service.
- If my Provider determines that the Telehealth Services do not adequately address my medical needs, my Provider may require an in-person medical evaluation. In the event the Telehealth session is interrupted due to a technological problems or equipment failure, alternative means of communication may be implemented or an in-person medical evaluation may be necessary.

Disclaimers:

Access to the Service and the information contained therein is provided "as is" and "as available" without any warranty of any kind, express or implied.

Without limiting the foregoing, neither my Provider nor any organization with whom my Provider is affiliated for the provision of Telehealth warrants that access to the Service will be uninterrupted or error-free, or that defects, in any, will be corrected; nor does it make any representations about the accuracy, reliability, currency, quality, completeness, usefulness, performance, security, legality, or suitability of the Service or any of the information contained therein. You expressly agree that your use of the Service and your reliance upon any of its contents is at your sole risk.

Age Requirements:

I hereby certify that I am at least 18 years of age and/or am legally qualified and able to under the laws of my state to make medical decisions on my own behalf, or on behalf of my minor child or the adult person on whose behalf I have requested this visit, if applicable. I acknowledge that my ability to access and use Telehealth Services, and information is conditional upon the truthfulness of my certification of age.

Patient Consent to the Use of Telehealth:

By signing below, I acknowledge the scope of care will be at the sole discretion of the healthcare provider who is treating me, with no guarantee of diagnosis, treatment, or prescription. I have read and understand the information provided above, and understand the risks of Telehealth, and by accepting these Terms of Use, I hereby give my consent for the use of Telehealth for my medical care.

Name: _____ **Signature:** _____ **Date:** _____

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The Office of Leila Rhodes M.D. / 6525 La Jolla Blvd, La Jolla, CA 92037 / 858-454-5557