DIANE L. OZOG, M.D, S.C.
1331 W. 75th Street - Suite 303
Naperville, Illinois 60540
(630) 652-0606 Fax: (630) 652-9900

CONSENT – TELEMEDICINE VISIT

I am giving consent for myself or my child (if under 18) to have a Telemedicine visit with a licensed medical professional from the office of Diane L. Ozog, MDSC. I understand Telemedicine involves the use of electronic communications to enable the healthcare provider to evaluate, diagnose and treat me or my child. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient information. I understand because this is a Telemedicine visit, there may be limits to the medical conditions which can be evaluated, diagnosed and treated using electronic communications.

Possible Risks:

As with any medical service or procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the provider;

- Delays in medical evaluation, diagnosis, and treatment could occur due to deficiencies or failures of the equipment;

- In rare cases, security protocols could fail, causing a breach of privacy of personal medical information;

By signing this form, I understand the following:

- I understand that Diane L. Ozog, MDSC will submit a claim for services rendered from this telemedicine visit to my insurance company. I understand that **Co-Payments**, **Co-Insurance**, and/or **Deductibles** may apply to this claim. I understand that I may receive a bill from Diane L. Ozog, MDSC for services not covered by my insurer. I understand and agree that I will remit payment in full to Diane L. Ozog, MDSC within thirty (30) days of receipt of a statement of balance due.
- I understand that the laws that protect privacy and confidentiality of medical information also apply to telemedicine and that no information obtained in the use of telemedicine, which identify me or my child will be disclosed for research purposes.
- I understand I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my or my child's care at any time, without affecting the right to future care or treatment.
- I understand I have the right to inspect all information contained in my or my child's medical record in the course of a telemedicine interaction, and may receive copies of this information for a reasonable fee.
- I understand that a variety of alternative methods of medical care may be available to me or my child, including an in person visit in the office, and/or a visit to the Urgent Care center or Hospital of my choice.
  My provider has explained the alternatives to my satisfaction.
- I understand that I may expect anticipated benefits of evaluation, diagnosis, and treatment from the use of telemedicine in my or my child's care, but that no results can be guaranteed or assured.

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Patient Consent to the Use of Telemedicine

I have read and understand the information provided above regarding telemedicine, have discussed it with my healthcare provider and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my or my child's medical care.

Authorization to Release Information:

I hereby authorize Diane L. Ozog, MDSC to release any information necessary to insurance carriers and/or the Centers for Medicare regarding the patient's illness and treatment and I hereby assign payment to Diane L. Ozog, MDSC for services rendered for myself and/or my dependent(s).

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Signature of Patient, Parent/Guardian (if under 18 years of age)

____
Printed Name of Patient, Parent/Guardian

____
Date