LOS ANGELES INTEGRATIVE
Gastroenterology & Nutrition
Whole-Person Approach to Digestive Care

Telephone or Video Conferencing Consent for Patients

GENERAL GUIDELINES:

- This service may be of value to those patients that live far away and wish to have our doctor review their data, perform an interview using TeleMedicine or phone or other video conferencing online technology to receive opinion and recommendations that they can discuss with their treating physician.

- This service may also be ideal for patients that have seen the physician at least one time and want to discuss labs and therapeutic plans or monitoring and/or their progress.

- The payment for the TeleMedicine consultation is used to cover records review, patient interview as well as the time required for documentation. We strongly recommend that patients take their own notes particularly of plans and recommendations. Formal report preparation may incur additional fee. The fee for the consultation does not cover for ongoing support after the consultation.

- Alternatively, patients have the choice to request follow up inquiries, which could be as short as 10 minutes.

- To make the best out of your consultation, please have the following items planned ahead of the time:

    - Your medical records that you wish our doctor to review. Ideally, these should arrive prior to your visit.
    - Be clear on your line of questions. What questions you would like to be answered during the session.
    - Write your goals that you wish to reach.
    - Fax or otherwise send us the completed MEDICAL HISTORY form(s) that we provide.
    - Make sure that WE HAVE your signed credit card authorization and credit card on file before the consultation. Also the Third Party Agreement if someone else is paying for the services you receive.
    - Review and sign the CONSENT below.
    - Review fee structure that is posted online

- Please note: A portion of the professional time will be used for documentation and implementation after the phone or video conferencing is completed.

Telephone or Video Conferencing Consent

- I hereby request a Telephone, TeleMedicine or other video conferencing consultation (VCC) using online technology.

- I acknowledge that I have been presented with the fee requirements/structure and GENERAL GUIDELINES associated with this service.

- I understand that this service will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider. I understand that I have the alternative to book an actual visit with doctor's office or another provider in my local area.

- I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my healthcare provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

- I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Other office staff members may also be present during the consultation other than the consulting healthcare provider. The above mentioned people will all maintain confidentiality of the information obtained.

- I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following:

    - Omit specific details of my medical history/physical examination that are personally sensitive to me. I agree to present this request in writing.

    - Ask non-medical personnel to leave the telemedicine examination room, and/or terminate the consultation at any time.

    - I have had the alternative to a telemedicine consultation explained to me, and yet I have chosen to participate in a telemedicine/VCC consultation.

    - Privacy and HIPAA compliance cannot be guaranteed with these methods of communication.

- By signing this form, I certify that I have read this form and I fully understand its contents including the risks. I have been given ample opportunity to ask questions and that my questions have been answered to my satisfaction.

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PATIENT NAME: _____ DOB: _____

SIGNATURE: _____ DATE: _____

If patient is a MINOR, please specify below:

I, _____ AM THE PARENT/MOTHER/FATHER/OTHER OF THE ABOVE PATIENT.

SIGNATURE: _____ DATE: _____

I, _____ AM THE LEGAL GUARDIAN OF THE ABOVE PATIENT.

SIGNATURE: _____ DATE: _____

PLEASE PRINT, SIGN AND FAX THE COMPLETED FORM TO (310) 203-4592. THANK YOU.