CENTRAL CARE CANCER CENTER
HEARTLAND CANCER CENTER
Radiation Oncology & Medical Oncology
Administration & Billing | 2337 E Crawford St | P.O. Box 256 | Salina, KS 67402-0256 | Office: 785-823-0633 | Fax: 785-823-0658

Consent for Telemedicine Services

I understand that I may be participating as a patient on the Central Care Cancer Center and/or Heartland Cancer Center Telehealth system that uses interactive tele-video (ITV) technology. The ITV equipment and telecommunication lines used in telemedicine consultations are secured to ensure patient confidentiality and privacy.

My Health care provider has explained to me how the video conference technology will be used to affect such a consultation, and that 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 there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

Others may be present during the consultation other than my health care provider and consulting health care provider in order to operate the video equipment. The 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: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room and or (3) terminate the consultation at any time.

I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a telemedicine consultation. I understand that some parts of the exam involving physical test may be conducted by individuals at my location at the direction of the consulting health care provider. In an emergent consultation, I understand that the responsibility of the telemedicine consultant specialist is to advise my local practitioner and that the specialist's responsibility will conclude upon the termination of the video conference connection.

I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. I understand that billing will occur from both my practitioner and as a facility fee from the site from which I am presented.

I have had a direct conversation with my doctor, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternative have been discussed with me in a language in which I understand.

By signing the form, the patient or guardian gives permission for the telemedicine services and that patient or guardian affirms that the ability to give consent is not impaired by any physical or mental conditions and has not been removed by a court of law.

_____	_____
Printed name of patient	Date
_____	_____
Signature of patient or legal guardian	Relationship of Legal Guardian

Authorization must be signed by the patient or by the nearest responsible relative in case of a minor; or when the patient is physically and / or mentally incompetent.