

Telehealth/Telemedicine Protocol:

(Patient confidentiality and quality of care)

Patient is called or talked to in office. Patient is informed of the option of a tele visit, depending on circumstance.

Front office staff will inform patient of procedure and compliance issues.]

Front office staff will obtain consent from patient directly if possible, or over the phone as verbal consent. The staff member performing the consent will sign and date the form, and an additional office staff member will verbally confirm with patient that they have consented to the Tele visit, and will also sign the form as a witness.

The front office staff will collect the co-pay from the patient and process through merchant services.

An on-line link will then be sent to the patient's email that is recorded in their chart, along with instructions on how to use it to access the Tele visit.

(SpecOrtho used the HIPPA compliant and secure audio/video services of Doxy.com)

The patient will have an appointment scheduled on the main schedule, and on the specific Tele schedule on the practice system.

On the day of the scheduled Tele visit, the patient will access the virtual waiting room via the link provided as above.

The Medical Assistant will then communicate with patient to obtain the information the MA would typically obtain from an in person visit, and then enter that data into the encounter. The location of the MA allows for privacy.

The treating provider will then communicate with the patient also in a private location. The visit will then be documented in an encounter in the patient's EHR as it would be performed with an in-person visit.

The Tele visit will be ended, and any additional scheduling will be preformed as above.

Informed Consent for Telehealth/Telemedicine Visit

I, _____ have been informed of the option of performing an office visit as a telehealth/telemedicine virtual visit. I understand the reason for the option, and all additional options have been discussed with me. I fully consent to meeting my health care provider on a virtual media platform, and agree to have all of my health records, current symptoms, and current treatment plan discussed over the virtual media. I understand this visit will be charged as a normal office visit or televisit as appropriate, and I agree to be responsible for all charges per the regular financial policy of SpecOrtho.

I have been informed of the option of Telehealth/Telemedicine and agree to proceed:

Patient Name: _____ DOB: _____

Patient Signature: _____ Date of Consent: _____

Person Taking Verbal Consent if signature not available: _____

Signature: _____

Person Witnessing Verbal Consent: _____

Signature: _____