Telemedicine services involve the use of interactive video and/or audio conferencing and enables health care providers to deliver services to patients who are not in the same physical location as the provider.

1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.

2. I understand that I will not be physically in the same room as my health care provider. I will be notified if anyone other than my healthcare provider is in the room and my consent obtained for that person.

3. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
   a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider may discontinue the telemedicine visit and make other arrangements to continue the visit.
   b. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.

4. I may revoke this consent at any time by calling RGU at 915-225-2020.

5. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.

6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
   a. I understand that my insurance carrier will have access to my medical records for quality review/audit.
   b. I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit.
   c. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.

7. I understand that this document will become a part of my medical record.

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand. I understand that these visits are regulated by the state in which my doctor and I are located even if we are in different states.

______________________________	______________________________
Patient/Parent/Guardian Printed Name	Patient/Parent/Guardian Signature
______________________________	______________________________
Witness Signature	Date

7420 REMCON CIRCLE, EL PASO, TX 79912
1400 GEORGE DIETER DR., #170, EL PASO, TX 79936
2201 NORTH STANTON ST., EL PASO, TX 79902
3100 LEE TREVINO DR., EL PASO, TX 79936
2545 SOUTH DON ROSER DR., LAS CRUCES, NM 88011