



New Patient Televisit Consent Form

Westminster Medical Clinic offers Televisit services for the appointment reasons listed in the box below. The appointment reasons may be updated periodically.

LAB RESULTS AND DIAGNOSTIC TEST RESULTS FOLLOW-UP VISIT with PCP
HEALTH COACHING & EDUCATION VISITS with Health Coach
MEDICATION REVIEWS with PCP or Clinical Pharmacist
BEHAVIORAL HEALTH VISITS (provided by Jefferson Center for Mental Health)
APPOINTMENT REASONS APPROVED or REQUESTED BY WMC

1. I agree that the medical provider determines whether or not the condition/results being discussed, diagnosed, and/or treated are appropriate for a Televisit. Although I may schedule a Televisit, if the medical provider believes it best for the patient to be seen in-office, the medical provider may reschedule the appointment as necessary. This includes situations in which I am having an emergent issue. If I am having a medical emergency prior to the telemedicine visit, I will call 911. If I am having an urgent issue during the Televisit, the medical provider will refer you to either: a) go to the emergency room or urgent care or b) schedule an in-office appointment at the clinic.
2. I agree to exclusively visit with the medical provider for the reasons listed in the above box. I will schedule a different appointments with a medical provider for all other issues, problems, or requests.
3. I understand my medical provider will follow all ethical guidelines equal to doing so at an in-office visit.
4. I understand my medical provider will be documenting the Televisit in the clinic electronic medical record, may transmit prescriptions if necessary and relevant to the appointment, and may offer any service relevant to the lab results or diagnostic test results.
5. The Televisit will be offered through patient platforms or Zoom (Health Coaching only). The application gives a specific conference video information to conduct the Televisit. All patient protection measures related to privacy and security are taken as are during an in-office visit. I acknowledge this application is no more or no less secure than other communication types.
6. I will not video record or audio record the Televisit.
7. I acknowledge that technology does not always work well and it is possible your visit may be shortened or not occur due to technology issues, internet issues at the clinic, or community/statewide power outages. I agree to hold the clinic harmless due to technical failures and realize my appointment may be rescheduled.
8. I acknowledge that Televisits are usually not covered necessarily by insurance companies. If I do not have health insurance, I agree to pay an upfront fee at the time of scheduling.
9. All policies and forms completed by you the patient, including forwarding your personal health information to a third party (all clinics/medical providers/other) as you have stated on WMC paperwork and the WMC Payment Policy continue to be valid.
10. If accessing Behavioral Health services with Jefferson Center for Mental Health (JCMH) clinicians on-site at WMC (integrated care at WMC), I acknowledge to follow all statements above and will follow JCMH policies that I have previously agreed.

I acknowledge all statements above by signing below.

Patient or Legal Guardian – Please Print

Date of Birth

Patient or Legal Guardian **Signature**

Date