Tigard - Serenity Wellness Clinic
12750 SW 69th Avenue, Suite 101
Tigard, Oregon, US - 97223

Telemedicine Consent Form (Rev 0121)

General Policies

I will be conversing with my physician via a HIPAA complaint program utilized through Serenity Wellness Clinic's EHR, Charm along with the Zoom platform (required for the video chat).

I will be using my own computer, tablet or smartphone which will require a camera, microphone and Zoom software application.

“Telemedicine” includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical information and education using interactive audio/video communications.

I must be and attest that I am physically located in the state of Oregon in order to receive care via telemedicine. I will not be required to sign this form for every telemedicine encounter, but I attest that I will always be physically located in the state of Oregon for all future telemedicine visits.

There are risks and consequences from telemedicine, including but not limited to the possibility that the transmission of my medical information could be disrupted or distorted by technical failures, despite best efforts on the part of my physician to prevent otherwise.

My physician will have final determination regarding whether or not the condition being addressed is appropriate for a telemedicine encounter and that I may be referred to another provider or scheduled for an in-person visit at a later date if my condition warrants such.

Recording of sessions is strictly prohibited.

Please select Yes or No to indicate that you understand and agree to these policies. * ☐ Yes ☐ No

Conditions of the Appointment

Your physician will need to be able to confirm it is you. You will need to be in good lighting so you can be seen clearly and identified. You are recommended to be in a safe, quiet and private space. It is your responsibility to ensure the privacy of your visit. If another person is visible on camera, you will be asked for verbal consent to discuss your medical care in front of them. If other people are present and out of sight, your consent is implied.

Make sure you are in a location with a strong wifi signal.

If you have equipment available to take your vitals such as temperature, pulse, blood pressure or pulse ox, please have those items near at hand.

Please select Yes or No to indicate that you understand and agree to these policies. * ☐ Yes ☐ No

Rights and Responsibilities

I understand I have the following rights in respect to telemedicine:

I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.

The laws that protect confidentiality of my medical information also apply to telemedicine.

Please select Yes or No to indicate that you understand and agree to these policies. * ☐ Yes ☐ No

Payments, Fees and Insurance

It is your responsibility to understand your insurance coverage and you are financially responsible for all charges assigned to you or denied by your insurance company or for all charges if we are not billing insurance. During the COVID-19 pandemic, insurance coverage for telemedicine services has been expanded, but each insurance company has a different "end date" for their coverage of telemedicine and these dates have been subject to change and are outside of our control. We will do our best to notify you if we are aware that you do not have coverage for telemedicine, but it is your responsibility to check with your insurance company if you have questions about your coverage. Please note that we are unable to bill Medicare, Medicaid (OHP) or Kaiser/CHP for telemedicine services.

Please select Yes or No to indicate that you understand and agree to these policies. * ☐ Yes ☐ No

Consent and Signature

By signing below, I consent to engage in telemedicine with Dr. Bijana Kadakia ND LAc of Serenity Wellness Clinic, LLC as part of my medical care. My signature below indicates that I have read and understand the above statements; that I accept responsibility for copays, coinsurance and any other fees not covered by my insurance company; and accept full financial responsibility for charges incurred for telemedicine services. This permission is valid from the date of signing through 12/31/2021.

PATIENT SIGNATURE * _____

DATE * _____

If signed by someone other than the patient, please sign and indicate relationship. Verification that you are legally authorized to sign on the patient's behalf may be required.