**ERIK S. JONES, DO**

**Board Certified Family Physician**

**Laci Bauer**

**Certified Family Nurse Practitioner**

222 N. 2ND ST, STE 311

BOISE, ID 83702

Phone: (208) 344-6080 Fax: (208) 344-6079

**TELEHEALTH CONSENT FORM**

I, \_\_\_\_\_\_\_\_\_\_\_, understand that telemedicine is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to Dr. Erik Jones and/or Laci Bauer, FNP-C providing health care services to me via telemedicine including, but not limited to; patient education, prescription refills, medication reconciliation, initiation and monitoring of treatment plan and ordering of appropriate tests.

I understand that it is at Dr. Erik Jones’s discretion whether or not the condition being diagnosed and/or being treated is appropriate for a telemedicine encounter.

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine. As always, your insurance carrier will have access to your medical records for quality review/audit.

I understand that I will be responsible for any copayments or coinsurances that apply to my telemedicine visit.

I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting Dr. Erik Jones at 222 N. 2ND ST, Ste 311 Boise, ID 83702 Phone: (208) 344-6080. As long as this consent is in force (has not been revoked) Dr. Erik Jones may provide health care services to me via telemedicine without the need for me to sign another consent form.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_