FAMILY FERTILITY CENTER **www.familyfertility.com**
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INFORMED CONSENT FOR TELEMEDICINE SERVICES AND AUTHORIZATION FOR TELEPHONE CREDIT CARD USE

PATIENT NAME: _______________________________________ BIRTH DATE: ___________________________

PARTNER NAME: ______________________________________ BIRTH DATE: ___________________________

Informed Consent for Telemedicine Services:

- **I/we understand that telemedicine is the use of electronic information and communication technologies by a healthcare provider used to deliver services to an individual when he/she is located at a different location or site than I/we are.**

- **I/we understand that the telemedicine visit will be done through a two-way video link-up. The healthcare provider will be able to see my/our images on the screen and hear my/our voices. I/we will be able to hear and see the healthcare provider.**

- **I/we understand that the laws that protect privacy and the confidentiality of personal health information including Health Insurance Portability and Accountability Act, commonly known as HIPAA, apply to telemedicine as well. However, because telemedicine requires electronic transmission of information over the internet, there is no guarantee of absolute security. I/we accept the increased privacy risk associated with telemedicine.**

- **I/we understand that charges for telemedicine services will be submitted to my insurance for reimbursement but there is no guarantee of payment by insurance. I/we agree to be financially responsible for any charges, deductibles, copays and/or coinsurances that apply to my telemedicine visits.**

- **I/we understand that I have the right to withhold or withdraw my/our consent to the use of telemedicine in the course of my/our care at any time, without affecting my/our rights to future care or treatment.**

- **I/we understand that by signing this form that i/we are consenting to receive health care services via telemedicine.**

Patient Signature: ____ Date: ____________________

Partner Signature: ____ Date: ____________________

Authorization for Credit Card Transactions by Telephone

I/we authorize Dr. H. Christina Lee, MD d/b/a Family Fertility Center to accept my credit card information given by telephone and to charge my credit card for agreed upon purchases. I/we understand that my/our credit card information will NOT be saved or kept on file and must be provided directly by me/us for each transaction.

Patient Signature: ____ Date: ____________________

Partner Signature: ____ Date: ____________________