BRIDGE DERMATOLOGY, PLLC
Telehealth Informed Consent

Provider Information:

- Provider's Name: Ryan M. Trowbridge, MD, FAAD
- License Number: 62735
- Address: 309 S 204th St. Suite #134, Elkhorn, NE 68022
- Phone Number: 402 686 5781

Telehealth Services:

I, the undersigned patient, consent to receive telehealth services from the above-named licensed healthcare provider ("Provider") whose contact information is also provided. I understand that telehealth involves the use of electronic communications to enable healthcare providers to deliver services to patients remotely. This may include videoconferencing, audio communication, store and forward transfer of information, and other forms of communication technology.

I understand that telehealth services may include, but are not limited to:

- Medical consultations: Diagnosis, treatment planning, and follow-up.
- Prescription refills: If deemed appropriate by the healthcare provider.
- Educational sessions: Providing information about my health condition and treatment options.
- Remote monitoring: Using electronic devices to track health indicators.

Miiskin Group ApS does not provide the Services; it hosts and maintains the platform through which Bridge Dermatology, PLLC and its engaged providers provide telehealth services.

Benefits and Risks:

I understand that telehealth services have benefits, such as increased access to healthcare, reduced travel time, and potentially lower costs. However, I acknowledge that there are risks, including but not limited to:

- Technical issues: Disruptions in audio, video, or data transmission, inaccurate representation of exam findings
- Security risks: Confidentiality breaches despite reasonable efforts to secure communication.
- Limitations in care: The primary difference between telehealth and direct in-person service delivery is the inability to have direct, physical contact with the patient. Accordingly, some clinical needs may not be appropriate for a telehealth visit and your Provider will make that determination.

Confidentiality:

I understand that my telehealth session will be treated with the same confidentiality as an in-person visit. However, I acknowledge that there are potential risks to privacy, such as unauthorized access by third parties.

I consent to the disclosing of my health information for the purposes of my treatment and care coordination, or for reimbursement related to those services provided to me.

Security Measures:

The electronic communication systems we use will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption. All the Services delivered to the patient through telehealth will be delivered over a secure connection that complies with the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Emergency Situations:

I understand that in case of an emergency or if I am in crisis, I should call 911 or seek emergency medical attention.

Billing and Insurance:

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I understand that normal fees apply for telehealth services and that insurance coverage may vary. I am responsible for any applicable co-payments, deductibles, or other fees.

Other Patient Acknowledgements:

- In choosing to participate in a telehealth visit, I understand that some parts of the Services involving tests (e.g., labs, bloodwork, biopsies) may be conducted at another location such as a testing facility, at the direction of my Provider.
- It is necessary to provide my Provider a complete, accurate, and current medical history and list of medications. I understand that I can log into my "Portal" [INSERT LINK OR DESCRIPTION OF HOW TO LOCATE THE PORTAL] at any time to access, amend, or review my health information.
- There is no guarantee that I will be treated by a Group provider. My Provider reserves the right to deny care for potential misuse of the Services or for any other reason if, in the professional judgment of my Provider, the provision of the Services is not medically or ethically appropriate.
- I understand that I may be asked to provide my identification and confirm my physical location prior to or during the telehealth visit.

Patient Consent:

I have read and understand the information provided in this consent form. I have had the opportunity to ask questions and have received satisfactory answers. I have the right to withdraw my consent to the use of telehealth at any time by notifying the provider.

Patient's Signature: _____
Date: ____/____/____

Name of minor patient's parent or legal guardian:

_____

Signature of minor patient's parent or legal guardian:

_____

Release of Medical Records to PCP:

Connecticut law (Sec 19a-1906) requires that a patient is asked if he or she consents to his or her medical records regarding these telehealth services be sent to his or her primary care provider. Consent is not necessary to proceed with these telehealth services.

I consent to having my records pertaining to these telehealth services sent to my primary care provider.

Name of Primary Care Provide:

_____

Patient's Signature: _____
Date: ____/____/____

Name of minor patient's parent or legal guardian:

_____

Signature of minor patient's parent or legal guardian:

_____