



OFFICE OF STUDENT LIFE

## STUDENT HEALTH CENTER

1. I understand that I will be participating in a telemedicine consultation with an Indiana University Student Health Center (IUSHC) health care provider. I understand that this consultation will not be the same as a direct patient/health care provider visit due to the fact that we will not be in the same room. In choosing to participate in a telemedicine consultation, I understand that a limited physical examination may be performed during the telemedicine visit.
2. I attest that I am physically present in the State of Indiana for the duration of the telemedicine visit.
3. I understand that the benefits to a telemedicine consultation include having access to medical care and education without having to travel to the SHC. A potential risk of telemedicine is that an in-person consultation or emergent care may still be necessary depending on my specific medical condition or due to technical problems.
4. I will have a direct conversation with my health care provider, during which I will have the opportunity to ask questions in regard to this procedure. My questions will be answered and the risks, benefits and any practical alternatives will be discussed with me in a language in which I understand.
5. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
6. I understand that I take full responsibility to provide a private space that will ensure privacy and confidentiality during the telemedicine visit. The provider has the right to terminate the telemedicine visit if the level of privacy and confidentiality is unacceptable. I will be informed of any others present in my health care provider's office and they will maintain confidentiality.
7. I understand that my healthcare information will be maintained to the same privacy standards as an in-person visit, but may be shared with other individuals for scheduling and billing purposes.
8. I consent for screen shots to be taken for documentation of certain medical problems as needed. I will be informed if a screen shot is necessary. The screen shot will become a part of my medical record although the video itself will not.
9. I understand that I will be charged for the telemedicine consultation and that billing will be done according to the IU Student Health Center's standard procedures.
10. I may withhold or withdraw my consent to the telemedicine consultation at any time without affecting my right to future care or treatment.

By signing this form, I attest that I:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of the telemedicine visit.