Hackensack Sleep & Pulmonary Center
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Dr. Fariborz Ashtyani and Dr. Deborah (Hutter) Goss
201-996-0230

TELEHEALTH INFORMED CONSENT

This consent is designed to provide written confirmation of the discussion between you and your practitioner, including information given regarding your condition and Plan of Care. State law requires that informed consent be obtained.

I authorize Dr. Fariborz Ashtyani and or/ Dr. Deborah Goss of Hackensack Sleep and Pulmonary Center and or their assistants to treat/educate me regarding my current health condition.

Introduction: Telehealth involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists and or subspecialists. The information may be used for diagnosis, therapy, follow ups and or education, and may include any of the following:

Patient medical records, Medical images, live two way audio and video, output data from medical devices and sound and video files.

Electronic systems used 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 the integrity against intentional or unintentional corruption.

Expected benefits: Improved access to medical care, counseling and education by enabling a patient to remain in a remote site. More efficient medical evaluation and management. It also allows the obtaining the expertise of a distant specialist.

Possible Risks: As with any medical procedure there are potential risks associated with the use of telehealth. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (ie., poor resolution of images) to allow for appropriate medical decision making by the physician, consultant and or their agents (respiratory therapists, nurse, et cetera).
- Delays in medical evaluation and treatment could occur due to deficiencies or failure of the equipment.
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information.
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgement errors.

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply the telehealth and that no information obtained in the use of telehealth which identifies me will be disclosed to researcher or other entities without my consent
2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that I have the right to inspect all information obtained and recorded in the course of a telehealth interaction and may receive copies of this information for a reasonable fee.
4. I understand that a variety of alternative methods of medical are may be available to me, and that I may choose one or more of these at any time. My doctor has explained the alternatives to my satisfaction.
5. I understand that it is my duty to inform my doctor of electronic interaction regarding my care that I may have with other healthcare providers.
6. I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.

The nature and purpose of the above described telehealth visit as well as its possible disadvantages, consequences, alternatives, risks, problems and risks of not receiving care have been reasonably explained to me and no guarantee or assurance has been made as to the results which may be obtained, recognizing that medicine and telemedicine is not an exact science.

I understand that during the course of the telehealth visit, unforeseen conditions may become apparent, which requires an extension or modification from that described above and I authorize that these may be performed.

The Platform Doxy.me and associated equipment and supplies used for telehealth may have access to the visit and or information.

I consent to the disposal of material/ information provided during this telehealth visit by appropriate providers/ authorities.

The above named physicians and entities may photograph, video record and or use any other mediums which result in the permanent documentation of my image for medical, scientific, educational and or research purposes, provided my identity is not revealed by them. I agree that any photographs taken in pursuant this authorization, which are not required by law to be retained, may be disposed of by my providers so long as the manner of disposition shall be permanent destruction. I have been given sufficient opportunity to ask questions about my conditions, risks of not receiving care, alternative care, risks of treatment, the procedures to be used, and the risks and the risks and hazards involved. All of my questions have been answered to my satisfaction and I have sufficient information to give this informed consent thereby consent to the above prescribed procedure with the understanding that this consent can be withdrawn by me at any time prior to the procedure/telemedicine visit.

I certify that this form has been fully explained to me and that I have read it or have it read to me and that I understand its contents.

I hereby authorize Dr. Goss and or Dr. Ashtyani to use telehealth in the course of my diagnosis and treatment.
I hereby give my informed consent for the use of telehealth in my medical care.

PATIENT NAME PRINT_____

SIGNATURE_____ DATE_____

Certification of Practitioner

I hereby certify that I have discussed the contents of the consent form with the patient and answered any questions, and in my opinion he/she understands what he/she has been told.

Electronically signed,
Deborah Goss, M.D / Fariborz Ashtyani, M.D.