

Patient Information and Consent Form  
For All CMA Telemedicine Sessions

**What It Is:**

Telemedicine lets a CMA doctor care for you or your child, when you cannot see him or her in person, using the Internet.

**During Your Session:**

The provider will ask you to confirm the state you are in. **You must physically be in the States of VA or MD or D.C. to video conference with our providers.**

The provider may discuss health history, exams, x-rays, and other pertinent health information.

A visual and/or partial exam may take place. This may happen by video, audio and/or with other technology tools.

A report of the session will be placed in your medical record. You may get a copy from your provider.

All laws about the privacy of your health information and medical records apply to telemedicine visits.

**Risks and Common Problems**

If there is an equipment, Internet problem or disconnect, your diagnosis or treatment could be delayed.

Internet security and privacy are not a guarantee.

Without a hands-on exam, it may be hard to diagnose your problem. You may be asked to schedule a visit in the office.

**Your Responsibility**

It is up to you to get more care if your health problem does not go away.

All sessions will be filed to your insurance by our office. We will make best efforts to make sure that they are covered but, as with any visit, we cannot guarantee coverage.

Having a telemedicine visit is your choice. Even if you have agreed to the session, you can stop the visit at any time. You can limit the physical exam.

It is up to you to make sure the setting on your end is private, and should only include people with whom you are willing to share health information.

If the parent/ guardian does not join the session at the time of the appointment, it will be considered a no show and a \$50 no show fee will be assessed.

**Patient Acknowledgment**

This form gives you facts about, and risks of telemedicine. You understand no guarantees have been made about success or outcome, and you agree to take part in a telemedicine session.

By submitting your written or electronic signature below, you agree that you have read, understand, and agree with these terms, and had all your questions about telemedicine sessions answered. I understand that I am returning this form via unsecured e-mail.

\_\_\_\_\_  
Signature of Patient, Parent/Guardian, or Responsible Party

\_\_\_\_\_  
Print Name

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Child's Name (Please Print) / DOB

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Child's Name (Please Print) / DOB

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Child's Name (Please Print) / DOB

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Child's Name (Please Print) / DOB

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Child's Name (Please Print) / DOB

\_\_\_\_\_  
Date

**Forms may be faxed or emailed to our offices at:**

Alexandria Office Fax: 703-914-5494; E-mail: [forms.alex@cmanva.com](mailto:forms.alex@cmanva.com)

Fairfax Office Fax: 703-691-4791; E-mail: [forms.ffx@cmanva.com](mailto:forms.ffx@cmanva.com)