Paul D. Saadi, M.D., FAAOS
Diplomate of American Board
Of Orthopaedic Surgery

Dallas Bone & Joint Clinic

Pavilion at Medical City Dallas
12222 N. Central Expwy • Suite 130
Dallas, TX 75243

ORTHOPEDIC AND RECONSTRUCTIVE SURGERY

Phone (214) 324-2471
Fax (214) 324-1734

www.dallasboneandjoint.com

Patient Consent
Video telemedicine and/or telephone consultation

I hereby consent to engage in a video telemedicine and/or telephone medical consultation with Dallas Bone and Joint Clinic. I understand that these modes of service include the practice of health care delivery, diagnosis, consultation, treatment, transfer of healthcare data. I understand that encrypted phone lines are likely not used and therefore confidentiality cannot be guaranteed if sessions are conducted in areas with unsecure Internet access (public WIFI). In addition, it is recommended that phones sessions occur in areas where you can assure privacy. The clinician cannot assure confidentiality of information on the patient's end.

I understand that I have the following rights with respect to telemedicine services:

1. I have the right to withdraw consent at any time without affecting my right to future care or risking the loss for withdrawal of any program benefits to which I would otherwise be entitled.
2. The laws that protect the confidentiality of my health care information also apply to telemedicine consultations. As such, I understand that the information disclosed by me, during the course of my treatment is generally confidential. I also understand this information from the consultation shall not be disseminated without my written consent.
3. I understand that there are risks and consequences from telemedicine consultations, including, but not limited to, the possibility, despite a reasonable efforts on the part of my doctor, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my health care information could be interrupted by unauthorized persons; and or the electronic storage of my health care information could be accessed by unauthorized persons. In addition, I understand that telemedicine services and care may or may not be as complete as face-to-face services. I also understand that if my doctor believes I would be better served by another form of consultation, an in-person office visit will be scheduled as a priority.

My signature below indicates that I understand the type and scope of information being disclosed as well as the risks associated with telemedical consultations. I have been offered the opportunity to ask questions regarding the use of this information, and I give consent.

Patient signature:_____ Name:_____ Date:_____
Or for minor:
Parent/guardian signature:_____ Name:_____Date:_____

I have legal authority to sign this on behalf of_____ Relationship:_____