

Carmine J. DeFusco M.D., P.A.

Allergy & Asthma
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Telehealth Consent Form

I, _____ hereby give Carmine J. DeFusco consent to perform a virtual visit via Zoom, FaceTime, Skype to evaluate/treat my current health condition in lieu of an in person visit. I understand that this consultation will not be the same in such a way that I will not be in the same room as the doctor.

I, _____ understand the my personal health information my be shared with staff members for the purpose of scheduling/billing. In addition, they may also be present during the evaluation for the purpose of documentation and/or filming.

I understand there are potential risks with this type of consultation such as, but not limited to: interruptions, unauthorized access and technical difficulties. I further understand the doctor may feel it necessary to terminate the evaluation/visit if the videoconferencing connections prove to be inadequate to continue.

I do understand that this visit will be billed to my insurance in accordance with current insurance regulations. At present time most insurance companies, including Medicare, are waiving patient co-insurance and copays for this type of evaluation. However, this is NOT guaranteed and will be determined once it is billed to your individual insurance plan. This visit may/will be recorded and saved in accordance with insurance regulations.

This signed consent will be stored in my EHR (electronic health record) and will remain in effect for one year from the day it is signed unless I revoke it, in writing.

Signature of Patient (parent if minor)

Date

