波士顿试管婴儿中心同意远程医疗服务
BOSTON IVF CONSENT FOR TELEMEDICINE SERVICES

远程医疗是通过电子通信而非面对面的看诊所提供的医疗保健。在远程医疗服务中，医学和心理健康信息用于诊断，咨询，治疗，疗法，追踪和教育。健康信息通过电子通信从一个站点互动交流到另一站点。此时，这种通信方式可能比面对面通信更优先考量。

Telemedicine is healthcare provided through electronic communication rather than an in person face-to-face visit. In telemedicine services, medical and mental health information is used for diagnosis, consultation, treatment, therapy, follow-up, and education. Health information is exchanged interactively from one site to another through electronic communications. At times, this method of communication may be preferred over face-to-face communication.

电子通信可以包括视频会议，电话咨询，静止图像的传输，电子医疗技术，患者线上用户和远程观察患者，所有这些都被视为远程医疗服务。

Electronic communications may include videoconferencing, telephone consultation, transmission of still images, e-health technologies, patient portals, and remote patient monitoring all of which considered telemedicine services.

远程医疗服务将不被适用于紧急通信或紧急请求。紧急通信应通过拨打我们的电话781-434-6500与值班医生沟通。
Telemedicine services will not be offered or used for emergency communications or urgent requests. Emergency communications should be made by calling our answering service at 781-434-6500 to speak with the physician on call.

所使用的互动式电子系统将结合网络和软件安全协议，以保护患者身份和影像数据的机密性，并包括有助于保护数据并确保其完整性免遭有意或无意破坏的措施。波士顿试管婴儿中心将尽一切努力使用安全的互动式电子系统。波士顿试管婴儿中心使用为医疗健康设计的Zoom（视频）的HIPAA（健康保险可转移性和责任制法）兼容版本，但是，如果使用其他商业服务，则会带来额外的隐私风险，并且可能无法提供安全的健康保险可转移性和责任制法兼容平台。

The interactive 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 help safeguard the data and ensure its integrity against intentional or unintentional corruption. Boston IVF will make every effort to use a secure interactive electronic system. Boston IVF uses a HIPAA compliant version of Zoom designed for Healthcare, however other commercial services if used, pose additional privacy risks and may not provide a secure HIPPA-compliant platform.

远程医疗服务的使用，我确认并同意如下：
In connection with the use of telemedicine services, I acknowledge and consent as follows:

- 远程医疗服务涉及电子或技术辅助格式传达我的医学/心理信息。
  Telemedicine services involve the communication of my medical/mental information in an electronic or technology-assisted format.

- 我了解电子通讯可用于传达高度敏感的医学信息，例如对人类免疫缺陷病毒/艾滋病的治疗或相关的信息，性传播疾病或成瘾治疗（酒精，药物依赖等）。
  I understand that electronic communication may be used to communicate highly sensitive medical information, such as treatment for or information related to HIV/AIDS, sexually transmitted diseases, or addiction treatment (alcohol, drug dependence, etc.).

- 我可以随时选择退出远程医疗。我决定退出的决定，不会影响我在波士顿试管婴儿中心之后的疗程。
  I may opt out of the telemedicine visit at any time. My decision to opt out will not affect my ability to receive future care at Boston IVF.

- 在诊疗室内，可能会伴随其他工作人员跟我的医疗保健提供者。
  Additional staff members may be present in the room with my healthcare provider.

- 我了解远程医疗账单的付款方式与一般面对面看诊的方式相同。我的财务责任，将由保险公司决定和管理，我有责任核实我的保险计划以确定承保范围。
  I understand that telehealth billing information is collected in the same manner as a regular office visit. My financial responsibility will be determined individually and governed by my insurance carrier(s), and it is my responsibility to check with my insurance plan to determine coverage.

- 我了解所有电子医疗通信都会带来一定程度的风险。尽管在安全的环境中，降低与使用远程医疗相关的风险的可能性，但是这些风险仍然是真实且重要的。这些风险包括但不限于：
  I understand that all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of telemedicine in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include but are not limited to:
  - 尽管采取了合理的预防措施，但在我不知情的情况下，更容易转发，截取甚至更改电子通信。
    It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge, despite taking reasonable preventative measures.
  - 安全协议可能会失效，从而导致我的隐私和个人健康信息受到侵犯。
    Security protocols could fail, causing a breach of my privacy and of my personal health information (PHI)
  - 雇主，朋友或其他人可进入使用的电子系统不安全，应避免使用。对我来说，使用安全的网络很重要。
    Electronic systems that are accessed by employers, friends, or others are not secure and should be avoided. It is important for me to use a secure network.
  - 波士顿试管婴儿中心使用为医疗健康设计的Zoom(视频)的健康保险可转移性和责任制法的兼容版本，但是，如果使用其他商业服务，则会带来额外的隐私风险，并且可能无法提供安全的健康保险可转移性和责任制法兼容平台。我承认这一点，并希望继续进行。
    Boston IVF uses a HIPAA compliant version of Zoom designed for Healthcare, however other commercial services if used, pose additional privacy risks and may not provide a secure HIPPA-compliant platform. I acknowledge this and wish to proceed.
  - 尽管我的医疗健康提供者做出了相当的努力，但由于技术故障，医疗信息的传输可能会受到干扰或扭曲。这种破坏或扭曲可能不允许我的医疗健康提供者做出适当的医疗决策。
    Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures. Such disruptions or distortion may not allow for appropriate medical decision-making by my healthcare provider.
  - 由于设备缺陷或故障，可能会导致医疗评估和治疗延迟。
    Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment.

- 我了解我必须采取合理的措施来保护自己，防止他人未经授权使用电子通讯。医疗健康提供者对由独立第三方或我造成的违反保密性的行为不承担任何责任。
  I understand that I must take reasonable steps to protect myself from unauthorized use of electronic communications by others and that the healthcare provider is not responsible for breaches of confidentiality caused by an independent third party or me.

- 我理解并同意，通过远程医疗进行医疗评估，可能会限制我的医疗服务提供者，全面诊断病情或疾病的能力。作为患者，我同意接受我的医疗保健提供者的建议，包括进一步的诊断测试（例如实验室测试，活检或办公室看诊。
  I understand and agree that a medical evaluation via telemedicine may limit my healthcare provider's ability to fully diagnose a condition or disease. As the patient, I agree to accept responsibility for following my healthcare provider's recommendations—including further diagnostic testing, such as lab testing, a biopsy, or an in-office visit.

- 我了解我的医疗保健提供者，可能会选择将我的信息转发给其他地区（包括外州）的授权第三方。因此，我已告知医疗保健提供者，不希望通过电子通信发送的任何信息。
  I understand that my healthcare provider may choose to forward my information to an authorized third party who may be located in other areas, including out-of-state. Therefore, I have informed the healthcare provider of any information I do not wish to be transmitted through electronic communications.

- 我同意在远程医疗访问期间交换的信息，将由治疗我的主治医生，其他医疗服务提供者和医疗机构维护。
  I agree that information exchanged during my telemedicine visit will be maintained by the physicians, other healthcare providers, and healthcare facilities involved in my care.

- 我了解医疗信息（包括医疗记录），适用于远程医疗的联邦和州法律管辖。还包括我查阅自己的病历（以及病历复印件）的权利。
  I understand that medical information, including medical records, are governed by federal and state laws that apply to telemedicine. This includes my right to access my own medical records (and copies of medical records).

我已充分了解到进行远程医疗看诊的风险，利益和影响，且已获悉可用的替代方式，包括延迟生育治疗，直到我可以面对面看诊，以及此类替代方案的风险和利益。
I have been fully advised of the risks, benefits, and implications of proceeding with my telemedicine visit and have been informed of the available alternatives, including delaying my fertility treatment until such time as I am able to have a face to face visit, and the risks and benefits of such alternatives.

我同意解除波士顿试管婴儿的委托人，董事，高层管理人员，股东，员工，佣人，代理人，联合管理公司和代表的损失，并使之不受损害，支出费用，负债，诉讼因由，诉讼和索赔（以下简称"责任"），是由于我决定通过远程医疗服务进行不孕治疗而引起的。
I agree to release and hold harmless Boston IVF its trustees, directors, officers, shareholders, employees, servants, agents, affiliates, management companies and representatives for any and all damages, expenses, liabilities, causes of action, suits and claims ("liabilities") caused by or arising from my decision to proceed with infertility treatment by means of telemedicine services.

我已阅读并理解本同意书中提供的有关远程医疗的信息，并有机会提出问题，我的所有问题都得到了满意的答复。通过在下面签名，我特此同意，在波士顿试管婴儿中心的诊断和不孕治疗过程中使用远程医疗。
I have read and understand the information provided in this Consent regarding telemedicine and have had the opportunity to ask questions and all my questions have been answered to my satisfaction. By signing below, I hereby give my informed consent for the use of telemedicine in the course of my diagnosis and infertility treatment at Boston IVF.

_____
患者签名
Signature- Patient

_____
患者配偶/伙伴（如使用的话）
Signature – Spouse/Partner (if applicable)

_____
正楷全名
Print Name:

_____
正楷全名
Print Name:

_____
日期 **Date:**

_____
日期 **Date:**