BOSTON IVF CONSENT FOR TELEMEDICINE SERVICES

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.

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.

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.

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 HIPAA-compliant platform.

In connection with the use of telemedicine services, I acknowledge and consent as follows:

- Telemedicine services involve the communication of my medical/mental information in an electronic or technology-assisted format.

- 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.).

- 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.

- Additional staff members may be present in the room with my healthcare provider.

- 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.

- 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:
    - It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge, despite taking reasonable preventative measures.
    - Security protocols could fail, causing a breach of my privacy and of my personal health information (PHI)
    - 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.

- 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 HIPAA-compliant platform. I acknowledge this and wish to proceed.
- 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.
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment.

- 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.

- 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.

- 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.

- 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.

- 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).

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.

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.

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.

_____	_____
Signature- Patient	**Signature – Spouse/Partner (if applicable)**
_____	_____
Print Name:	**Print Name:**
_____	_____
Date:	**Date:**