Kevin Lunde, M.D.
Board Certified Otolaryngologist
& Facial Plastic Surgeon

TELEHEALTH CARE
PATIENT INFORMED CONSENT

I hereby consent to receiving treatment through telehealth from Dr. Kevin Lunde or a qualified member of his staff. I understand that "telehealth" is the mode of delivering health care services via interactive audio, video, and/or data communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a patient's health care. I understand that telehealth also may involve the communication of my personal health information, both orally and visually, to other health care practitioners, including my primary care provider.

I understand that I have the following rights with respect to telehealth:

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment or risking the loss or withdrawal of any program benefits to which I would otherwise be entitled. I understand that receiving treatment through telehealth does not mean I cannot receive in-person health care services, either today or in the future. I understand that there are limitations to the types of treatment that can be appropriately provided via telehealth, and that if my provider believes I would be better served by another form of medical care (e.g., in-person service), I will be referred to a provider in my area who can provide such service.

(2) The laws that protect the confidentiality of my medical information also apply to telehealth care. In addition, I understand that it is my responsibility to ensure that my physical location during videoconferencing is free of other people to ensure my confidentiality.

(3) I understand that I may benefit from telehealth, but that results cannot be guaranteed or assured. I also understand that there are risks involved in receiving treatment via telehealth, such as interruption of the audio-video connection between my provider and me, or delays in receiving medical treatment because of technological failures.

(4) I understand that I have a right to access my medical information and copies of medical records in accordance with Texas and federal law.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of telehealth.
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Date: _____

_____
Signature

Print Name: _____
If signed by other than patient:
Relationship to Patient (Check One):

☐ Parent ☐ Legal Guardian ☐ Other: _____

PATIENT COMPLAINT PROCEDURE

While we hope every patient's visit goes smoothly, it is important that we are notified of patient concerns so we can take appropriate steps to address them.

Complaints about physicians, as well as other licensees and registrants of the Texas Medical Board, may be reported for investigation at the following address:

Texas Medical Board
Attention: Investigations Department
MC-263 P.O. Box 2018
Austin, TX 78768-2018

Assistance for filing a complaint is available by calling: 1 (800) 201-9353

For more information, please visit the Texas Medical Board website at www.tmb.state.tx.us.