SEASIDE DERMATOLOGY & SKIN CANCER CENTER

TELEMEDICINE VISIT INSTRUCTIONS

Thank you for using Seaside Dermatology & Skin Cancer's telemedicine platform! You have chosen to be virtually treated by one of our providers.

STEP 1: FILL OUT ALL NECESSARY FORMS

Prior to starting your Telederm visit, either take a picture of the documents or scan and email the signed forms to seasidedermdr@gmail.com. The forms we will need to send us are:

- ❑ Telemedicine Consent/Pharmacy Info
- ❑ Credit Card Authorization
- ❑ For New Patients ONLY: New Patient Registration + Photo ID + Image of Insurance Card

YOU WILL NOT RECEIVE A LINK FOR THE TELEMEDICINE VISIT UNTIL ALL OF THESE DOCUMENTS HAVE BEEN PROVIDED TO US***

STEP 2: CLICK ON YOUR ZOOM LINK 5 MINUTES PRIOR TO YOUR APPOINTMENT TIME
(see email from us for the link & please call us at 949-552-1313 if you run into any technical difficulties)

Please "join" the meeting 5 minutes prior to the start time to ensure everything is set up correctly on your end by clicking on the link in the email sent to you.

Upon joining the meeting, it may ask you to download the Zoom Desktop Client. This will give you the best video/audio experience. If you are unable to do this, you can still join the meeting by selecting the browser link option.

The provider may be finishing up with another patient and may not be in the meeting immediately upon you joining the meeting. You will be in a virtual waiting room until the provider is able to see you.

Once your visit is done, please exit the Zoom Desktop Client.

SEASIDE DERMATOLOGY & SKIN CANCER CENTER

CONSENT TO PARTICIPATE IN TELEMEDICINE CONSULTATION

Purpose: This form is intended to obtain your permission to participate in a telemedicine consultation.

Introduction: Telemedicine is the use of video conferencing to enable healthcare providers at a different location to provide health care treatment to you and/or consult with you and your health care provider about your health care options and decisions. Telemedicine consultations are not the same as direct patient/healthcare provider visits, as you will not be in the same location as the consulting provider. Telemedicine allows Seaside Dermatology & Skin Cancer Center to provide services to you that may otherwise require you to travel. Your participation in any telemedicine consultation is completely voluntary.

Process: By signing this form, you are acknowledging that you understand the following:
• Details of your medical history, including but not limited to, images, x-rays and tests may be shared electronically and discussed with the consulting provider.
• Non-medical personnel may be present to assist in operating video conferencing equipment. You will be informed of any non-medical personnel present during the video conference.
• Video, audio, and/or photo recordings may be taken during the procedure to aid in documenting the progress of your treatment.
• The responsibility of the consulting provider regarding your health care will terminate upon conclusion of the teleconference.
• Your provider as well as the consulting provider may keep a record of the consultation.

Possible Risks: By signing this form, you are acknowledging that you understand the following:
• Despite our best efforts to protect the privacy of patient information, security protocol could fail causing a breach of privacy of personal medical information.
• Information provided by telemedicine to the consulting provider may be insufficient to allow for treatment and general medical care decision to be made.
• Delays in medical evaluation and treatment may occur due to failures of the electronic equipment.

Consent: By signing this form, you are consenting to participate in a telemedicine consultation. You are acknowledging that you have read and understand the provisions in this form. If you are unable to read, you are acknowledging that a proxy has read this form to you. You are acknowledging that you understand how telemedicine video conferencing works.

Duration: This authorization shall be effective immediately and remain in effect until a written notice of revocation is sent to Seaside Dermatology & Skin Cancer Center at the office address: 4950 Barranca Pkwy #307 Irvine, CA 92604

I hereby consent to participation in a telemedicine consultation. A photocopy or facsimile of this authorization shall be considered effective and valid as the original. I have been advised of my right to receive a copy of this authorization.

Please send me the telemedicine link to the following email address:

_____

_____ _____
Patient Name Date

_____ _____
Signature of Patient Witness

_____ _____
Signature of Authorized Representative Relationship to Patient

PHARMACY INFORMATION:

Please let us know where you would like your prescription(s) to be sent to if applicable:

Pharmacy Name:_____

Pharmacy Phone:_____

Pharmacy Address:_____

_____

SEASIDE DERMATOLOGY & SKIN CANCER CENTER

CREDIT CARD AUTHORIZATION FORM

PATIENT NAME:_____

PATIENT DATE OF BIRTH:_____

DATE OF SERVICE:_____

I authorize Seaside Dermatology & Skin Cancer Center to charge my share of the cost associated with my telemedicine office visit (applicable copay, deductible, and/or coinsurance) .

Patient Signature:_____

Date:_____

☐ VISA ☐ MasterCard

Cardholder Name: _____

Credit Card #: _____

Expiration Date: _____

Security Code: _____

4950 Barranca Pkwy, Ste 307 | Irvine, CA 92604 | (P) 949.552.1313 (F) 949.552.0340