



Full Name _____
Last First M/I

Date of Birth: _____ Sex (circle one): M or F

Address: _____
Street address City, State, Zip

Phone : _____ Alternate Phone: _____

Preference of method of consultation (circle one) : Phone call or teleconference, such as Facetime

Diagnosis : _____

Primary reason for requesting a pathology consultation:

Referring Physician: _____

Signature : _____ Date: _____

*Send completed form to admin@personalpathology.com

Or fax back to 605-791-1711



TELECONSULT PATIENT CONSENT FORM

I, (name of patient or parent/guardian)

_____, agree to participate in a phone or telehealth evaluation with Personal Pathology Consulting, LLC. By signing this agreement, I authorize the electronic transmission of my medical information.

I understand that as with any technology, telehealth does have its limitations. I understand that this telehealth session will not eliminate the need for me to continue my current course of treatment.

I understand that all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are real and important to understand. These risks include but are not limited to: interruptions, unauthorized access, and technical difficulties.

I understand it may be necessary to discontinue and reschedule the telehealth consultation if it is felt that the videoconferencing connections are not adequate for the situation.

I understand that Skype, Zoom, WebEx, FaceTime, or a similar service, although stated as secure, may not provide a secure HIPPA-compliant platform, but I willingly and knowingly wish to proceed.

I understand that telehealth involves the communication of my medical and possibly mental health information in an electronic format.

I agree that I have verified to Personal Pathology Consulting my identity with state-issued photo identification and current location in connection with the telehealth consultation.

I understand that electronic communication may be used to communicate, although not common in a pathology report, highly sensitive medical information, such as treatment related to HIV/AIDS, sexually transmitted diseases, or addiction treatments.

I understand that Personal Pathology Consulting (PPC) will educate and clarify all medical terminology that is contained in the report. In no way will PPC attempt to provide a second opinion to what is originally documented in my pathology report. I understand that no further details extending beyond the scope of the pathology report, according to the signed physician's findings, will be provided by PPC.

I understand that the purpose of the consultation is to review and clarify my pathology report. I agree that I will not receive recommendations on course of treatment and debate whether my diagnosis is accurate.

I understand that medical records of telehealth services will be kept at the referring site facility, if applicable, and upon execution of the consultation, Personal Pathology Consulting will destroy any medical documents pertaining to the completed consultation. I agree to have my telehealth medical records reviewed for the purposes of consultation only.

I understand that I will not use the educational information provided by Personal Pathology Consulting in any legal matters.

By signing below, I understand the inherent risks of errors or deficiencies in the electronic transmission of health information during a telehealth consultation.

To the extent permitted by law, I agree to waive and release Personal Pathology Consulting and the consulting pathologist from any claims I may have about the telehealth consultation.

No recordings, visual or audio will be permitted during any part of the telehealth consultation.

I certify that I understand the nature of this agreement or as a legal guardian, have explained this agreement to the patient.

Signature of patient (or parent/guardian):

_____ Date: _____

Please print the above name:

_____ Date: _____

Additional family members who will observe consultation, if applicable:

-----payment disclosure section -----

I _____ understand that payment is required for all services at the time they are rendered.

I understand that I am fully financially responsible for all charges as Personal Pathology Consulting does not bill insurance. Personal Pathology Consulting accepts credit cards or electronic payment platforms such as PayPal and Venmo. I understand that once the consultation has begun, I am fully responsible for the full charges associated with the consultation even if the consultation is ended early at the patient's discretion. Payment is expected within 10 days of the date of service. If payment is not received within 10 days of the date of service, a service charge may be applied. I understand that payment is expected and appreciated at the time of service. Failure to pay the bill, will result in additional fees for collection agency or attorney costs.

I understand that if my account is turned over to collections for non-payment, an additional \$30.00 collection fee will be added to my account.

Signature of patient (or parent/guardian):

_____ Date: _____

*Send completed form back to admin@personalpathology.com

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