Kagen Dermatology Clinic S.C.
Charles N. Kagen, M.D.
100 W. Lawrence St. Suite 409
Appleton, WI. 54911
Tel: (920) 733-5138

TELEMEDICINE PATIENT CONSENT FORM

I, (name of patient or parent/guardian)_____, agree to participate in a telemedicine evaluation. By signing this agreement, I authorize the electronic transmission of my medical information and/or video conference session so that it can be viewed by a doctor and other persons involved in my medical care. I understand that a live telemedicine video conference will be billed the same as an in-office visit.

I understand that as with any technology, telemedicine does have its limitations. There is no guarantee, therefore, that this telemedicine session will eliminate the need for me to see a specialist in person.

I understand that medical records of telemedicine services will be kept at Kagen Dermatology Clinic S.C.

Signature of patient (or parent/guardian):_____Date:_____

Please print the above name:_____

Signature of witness:_____Date:_____