Chesterfield Ophthalmology - Patient Consent for Telemedicine Services

Due to the inability of being seen in the office due to COVID-19 restrictions and precautions, I give my consent to discuss my medical condition, be evaluated, and receive medical treatment by telecommunication methods. I understand that the evaluation is not equivalent to an in-person encounter, but serves as the best medical management of my condition that can be provided using remote telephone and visual images as indicated.

Additionally, I agree that any telemedicine services rendered by Stephen Busch, D.O. may be billed to my insurance carrier for appropriate reimbursement.

_____ ___ / ___ / _____

Patient Name Date of Birth

_____ ___ / ___ / 2020

Patient (or Legal Guardian/Guarantor) Signature Date