KATHY KRAUS, R.D., CD-N

REGISTERED DIETITIAN
CT LICENSE NUMBER: 000222
NPI Number 1487770145
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1458 BEDFORD STREET
STAMFORD, CT 06905
OFFICE: 203-324-4033
CELL: 203-912-9449
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INFORMED CONSENT FOR TELEMEDICINE SERVICES

Patient Name ___________________________________ Date of Birth _____________

Patient Location- _____________________________ Date of Consent_____________

I understand that telemedicine is the use of electronic information and communication technologies at a different site by a medical provider to deliver services to an individual when he/she is located at a different site than the provider. This would allow Kathy Kraus to conduct my session by computer or another device vis-à-vis a private video modality. I hereby consent to Kathy Kraus providing healthcare services to me via telemedicine. Kathy Kraus may also provide a telephone only visit without video in certain circumstances.

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine. Your insurance carrier reserves the right to have access to your medical records where necessary for billing and audit purposes.

Our office will be submitting your telemedicine claim to your health insurance for payment. Telephone visits without video may not be covered by your insurance. I understand that I may be responsible for any copayments, coinsurances or visits that are not covered by my insurance, that apply to my telemedicine visit.

I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting Kathy Kraus at 203-914-9449. As long as this consent is in force or has not been revoked, Kathy Kraus may provide healthcare services to me via telemedicine without the need for me to sign another consent form.

Patient name printed: ________________________________ Date: ___________________
Signature of Patient:____ __
Authorized signature if patient is minor or unable to sign: ___________________________

Please keep a copy of this consent form in your records.