TELEOPTOMETRY CONSENT FORM

Teleoptometry is a method of delivering eye care services using telecommunication technologies, allowing for remote vision examination, and treatment by an optometrist. This innovative approach enables for patient to access eye-care at anytime without an optometrist present.

- Teleoptometry involves the use of digital tools and software for video-conferencing, keeping electronic health records, digital imaging, etc. to conduct eye exams.
- There are some limitations to teleoptometry, such as the following:
  - Due to the nature of telecommunication, there may exist issues with connection resulting in poor quality of image being transmitted. This issue might impact the accuracy of a diagnosis.
  - Technical issues, or connectivity problems can also delay the process of the vision exam.
  - Access to medical records are limited for teleoptometry practitioners, as they may not have the full access to a patient's medical records/history. This may affect the comprehensiveness of the care provided.
  - Data Security, although our software is within the HIPAA compliance, and stringent measures are implemented to protect patient data, the use of electronic communications increase the risk of data breaches.

By singing this form you acknowledge your understanding of these limitations and agree to proceed with the teleoptometry eye exam.

CONSENT FOR ELECTRONIC COMMUNICATIONS

You hereby consent to the use of electronic communications, including but not limited to text messages, emails, and other digital means for the purposes of conducting the teleoptometry eye exam, and related follow-up care.

ACKNOWLEDGMENT OF RISKS AND QUESTIONS

You acknowledge that you have been informed of the potential risks associated with teleoptometry, including those mentioned above. You confirm that you have had the opportunity to ask questions regarding the teleoptometry eye exam and have received satisfactory answers to all your questions.

CONSENT

I hereby consent to receive eye care services through teleoptometry. I have read and understood the information provided in this consent form, including the explanation of teleoptometry, its limitations and potential risks. I agree to the use of electronic communications as part of this care.

Printed Name of Patient: Date:

_____ _____

Patient's or Patient's Legal Guardian's Signature:

_____