Storm
CLINIC

Telemedicine Intake and Exam Form

PATIENT NAME: _____ **DOB**: ___ /___ /____ **DATE OF VISIT**: ___ /___ /____

FAX ORDERS TO (DISTANT SITE): _____-____-_____ **ATTENTION:** _____

SITE NURSE: _____ **PEOPLE IN ROOM:** _____

PREFERRED PHARMACY: _____

SMOKING:Y/N **DIABETES**:Y/N

FLU VACCINATION: Y / N Date: ___ /___ /____ **PNEUMONIA VACCINATION**:Y /N Date: ___ /___ /____

CURRENT MEDICATIONS: (*OK TO INCLUDE ATTACHEMENT*)

_____

ALLERGIES: _____

Physical Examination:

GENERAL: Alert and Oriented x 3, NAD; _____

VITALS: HT: _____ WT(kg): _____ Temp: _____ Pulse: _____ BP: _____ RR: _____

HEENT: Normal Y/N, Abnormal:Y/N _____

RESPIRTORY/LUNGS: Normal:Y/N, Abnormal:Y/N _____

HEART/VASCULAR: Normal:Y/N, Abnormal:Y/N _____

CHEST/THORAX: Normal:Y/N, Abnormal:Y/N _____

GI/ABDOMEN: Normal:Y/N, Abnormal:Y/N_____

EXTREMITIES: Normal:Y/N, Abnormal:Y/N _____

SKIN: Normal:Y/N, Abnormal:Y/N _____

MUSCULOSKELETAL: Normal:Y/N, Abnormal:Y/N _____

NEUROLOGIC: Normal:Y/N, Abnormal:Y/N _____

PSYCH: Normal:Y/N, Abnormal:Y/N _____

TELEMEDICINE HIPAA AND PRIVACY FORM

I understand and agree to participate in a telemedicine encounter with Dr. Jeremy Storm, D.O. who is a Physician with the Storm Clinic Prof. LLC, Infectious Disease and Internal Medicine, and I understand and agree to the use of said telehealth functionalities in my care.

Risks of participating in a telemedicine visit include, but may not be limited to:

- The connection may fail to work or may be disconnected during an encounter which might result in delays in care
- If it is felt that the care rendered during the visit is not sufficient to appropriately address my problem or provide adequate care I may be required to see my provider in person
- In very rare instances, security protocols could fail, causing a breach of privacy of personal and medical information - in these situations, my providers will utilize any and all means necessary to correct the error as outlined in the policies related to HIPAA, Privacy, and Terms of Use and will notify me of the status of such breach and attempts at correction
- My insurance may not cover telemedicine services rendered and I may be required to pay for such service

Benefits of participating in a telemedicine consult include:

- I will have access to medical providers without the costs associated with travel
- I will be able to stay close to home and in proximity to my family and caretakers
- Telehealth will continue to grow and be widely utilized by my providers in the future
- Telehealth reduces overall costs of medicine and is beneficial for patients, insurers, and providers
- The technology needed to perform telemedicine is constantly improving

I understand that ancillary staff, nurses, medical assistants, respiratory therapists, doctors, and other such healthcare employees may be present during the telehealth visit, whose presence may be required for the purposes of obtaining an adequate intake, history, physical examination, or operating equipment. I understand that I have the right to discontinue the telehealth encounter at any time without it affecting my right to further care or treatment. I understand that any and all laws related to medical practice, privacy, and confidentially also apply to telemedicine. I have read
this document and understand the risks and benefits as listed above and have had my questions adequately answered. I hereby consent to participate in said telemedicine visit under the conditions described in this document.

Patient/Legal Representative Signature	Relationship	Date/Time

Witness	Date/Time