

## ANGELS – Follow Up Patient Packet

Antenatal & Neonatal Guidelines, Education & Learning System

Telemedicine Clinic

1.866.273.3835 (toll free)

Your telemedicine appointment has been scheduled. Please arrive 10-15 minutes early for your appointment. The information below should help you know what to expect at your visit. Please understand that the equipment shuts down automatically, so it is VERY important that you arrive on time with your completed paperwork. If you are 15 minutes late, you will need to reschedule. Please call our toll free number 1.866.273.3835.

Please remember to **bring all forms mailed to you** including the Consent Forms, Genetics Information and Acknowledge of Receipt of Privacy Notice. These forms should be completed BEFORE you arrive for your appointment. Your completed paperwork is essential. It is needed for an accurate, updated medical record.

**Bring Blood Sugar Logs to Clinic Every Visit.**

**What to Expect:** Your telemedicine appointment will be a lot like other doctor appointments you have experienced.

Just like usual doctor appointments, you will go into a patient room. If you prefer, family members may be invited into the room with you. The door to the room will be closed for privacy. A physician, nurse and/or ultra-sonographer will also be in the room. You will receive the same kind of exams that you would receive during a usual appointment.

You will see a piece of equipment that may look like a TV or it may have two screens and a small camera. Using the equipment, you will be introduced to the health care professionals at UAMS. You will be able to see and hear them, and they will be able to see and hear you. You may move and talk naturally. If you have an ultrasound, you, the health care providers at your local clinic and the professionals at UAMS will be able to look at it. The health care providers at your local clinic and UAMS will discuss your situation. You will be part of the discussion, so the UAMS providers may ask you questions. Do not hesitate to ask any questions.

The basic difference with a telemedicine appointment is that you will be talking with a physician or health care professional who is not in the same room with you. Though they are actually at UAMS, the telecommunication equipment allows you to see, hear and communicate with the health care providers at UAMS almost like they were standing next to you.

Keeping this appointment is very important. We hope that telemedicine will save you some travel time and inconvenience. Your input is valuable and helps us improve access and quality of health care. **When your session is finished, please fill out the *Telemedicine Patient Post-Session Evaluation Form* in your packet.** If you have any questions, please feel free to call us toll free at 1.866.273.3835.

## Authorization and Consent for Third Party Patient Account Responsibility

### To Be Completed By Patient:

I hereby authorize and give consent for billing statements of my treatment by UAMS to be mailed to the person named below, at the address indicated below. I understand that the billing statement includes a description of services provided. I further understand that this person will accept full responsibility as the Guarantor of my patient account to pay any balance remaining after insurance has paid.

\_\_\_\_\_  
Name of Designated Account Guarantor (Please Print)

\_\_\_\_\_  
Address to which account statements are to be mailed (Please Print)

\_\_\_\_\_  
City State Zip Code

\_\_\_\_\_  
Signature of Patient or Guardian Date Time

### To Be Completed by Designated Account Guarantor, if the Patient is not the Guarantor:

I agree to accept full financial responsibility for charges incurred by the above named patient for services rendered by UAMS. I agree to pay such charges or any balance remaining after the patient's insurance has paid.

\_\_\_\_\_  
Signature of Account Guarantor Date Time



(Place MR Label Here)

MR#:

Patient's Name:

Patient's Address:



### Authorization & Consent to Videoconference(s) with the ANGELS Telemedicine Clinic

Patient's Name: \_\_\_\_\_

Consent is good for videoconferences to end \_\_\_\_\_, 20\_\_

I understand that my image and my Protected Health Information will be transmitted electronically through the videoconference(s) to physicians, healthcare professionals and to other UAMS personnel. I understand that the individuals receiving my information are authorized to receive the information. I understand that the information received is for the purpose of providing medical diagnostic assessment and treatment services to me. I understand that the risk of unauthorized persons intercepting the transmission is extremely small. I understand that any videotape(s) which are recorded will not disclose my identity and will be used only for data collection, research and educational purposes.

I understand that I may withdraw my permission at any time prior to the videoconference or during the videoconference(s). I understand that no action will be taken against me for withdrawing my permission. I understand that if I interrupt the videoconference, it will be incomplete and cannot be used to provide treatment or services for my current condition. I understand that I may still get a consultation with a doctor or other healthcare professional. I understand that there are limits to Telemedicine technology, therefore, there is no guarantee that this Telemedicine session will get rid of the need for me to see a doctor in person in order to receive appropriate or additional treatment for my current condition.

I have received and read the ANGELS Telemedicine Information sheet.  
I have read this Authorization.  
I have had the opportunity to ask questions and am satisfied with the answers.

I give my consent to participate in the UAMS ANGELS Telemedicine videoconference(s).

\_\_\_\_\_  
Patient/ Legal Representative's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

\_\_\_\_\_  
Printed Name of Patient/Legal Representative

\_\_\_\_\_  
Witness' Signature



(Place MR Label Here)

MR#:

Patient's Name:

Patient's Address:

ANGELS Program Evaluation

Consult Date:     Consult Number:       Pt. ID:

For Telehealth Office Use Only

Patient:       Please put the first initial of first name, the first initial of middle name and the first 4 letters of last name. Example: John Paul George would be GPGEOR. If you do not have a middle name please use an X.

Patient Name: (write full name as: Last Name, comma First Name space Middle Name or Initial. Exp: Smith, Jane T (do not use periods))

SSN:           Date of Birth:

Address (Please separate with spaces, no periods)

City:                 State:

Zip:      County:           Phone:

Sex:  female  male

Have you ever been a patient at UAMS?  yes  no

Marital Status:  single  married  divorced  widowed

1. What is your race/ethnic group:  African-American (black)  American Indian, Alaskan Native, Alout

Caucasian (white)  Hispanic  other:

2. What is your primary health insurance?  none  Medicaid  Medicare  CHAMPUS

Commercial Insurance - Managed Care (HMO)  Other commercial insurance  not applicable

other:

Policy Number:

Name of Commercial Insurance Company

Insurance Company Address

Insurance Company City, State, Zip

3. What type of work do you do?  retail or wholesale trade  manufacturing  Mining or construction

agriculture, forestry or fishing  retired  finance, insurance or real estate  state government

unemployed  local government  transportation, communications or utilities  health care related

other:

4. In which of the following categories does your household's annual income fall?  up to \$25,000  \$25,001 to \$50,000

\$50,001 to \$100,000  more than \$100,000  decline to answer  not applicable (e.g., child, student)

5. How much schooling have you completed? (check most advanced level)  less than high school diploma  GED or high school diploma

some college/vocational school bechelor's degree  graduate degree  decline to answer

6. How familiar are you with telemedicine? (check the answer you most agree with)  I've had other telemedicine visits

I know what telemedicine is, but I've never used it until today  I've heard of telemedicine, but I don't know what to expect for today's visit

I don't know anything about telemedicine

7. How many people live in your household, including yourself?



(Place MR Label Here)

MR#:

Patient's Name:

Patient's Address:



### ANGELS Program Evaluation

Consult Date:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Consult Number:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Pt. ID:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
For Telehealth Office Use Only																	
Patient:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	Please put the first initial of first name, the first initial of middle name and the first 4 letters of last name. Example: John Paul George would be GPGEOR. If you do not have a middle name please use an X.									

1. Have you ever used telemedicine before? (mark only one)  
 yes, more than 5 times     yes, 1-5 times     no
2. Were you given a good explanation of what to expect before the session began? (mark only one):  
 yes     no     not applicable
3. Were you communication with a provider on a TV monitor, or over the telephone, during your session?  
 yes, on a TV monitor     yes, over the telephone     no (go to question #8)

	strongly disagree	disagree	undecided	agree	strongly agree
4. I was satisfied with the picture quality:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. I was satisfied with the sound quality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. I was satisfied with my talk with the provider	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. I talked about my concerns openly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. I did not have to wait too long to see the provider	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. I felt comfortable during the visit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. I have been told when to expect the results of this session	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. I know whom to contact with any questions related to today's session	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. I was satisfied with the quality of care I received today	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Overall, I was satisfied with today's session	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. After today's session, I am more willing to use telemedicine if my doctor recommends it	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

15. To attend this session, I traveled (choose only one):  
 less than 30 miles     31-50 miles     51-70 miles     more than 70 miles
16. I prefer having a telemedicine session rather than seeing the provider in person  
 strongly disagree     disagree     undecided     agree     strongly agree
17. If I did not use this telemedicine session for treatment, I would have to travel (choose only one):  
 less than 30 miles     31-50 miles     51-70 miles     more than 70 miles
18. If I did not use this telemedicine session for treatment, the cost of traveling to a specialist, missing work and other expenses for me and my family would be (choose only one):  
 a) less than \$35.00     b) \$35.00-\$75.00     c) \$75.00 - \$150.00     d) \$150 - \$300     e) more than \$300.00
19. If I did not use this telemedicine session for treatment, I would have to miss work for (choose only one):  
 no days     1/2 day     1 day     2 days     more than 2 days
20. Without telemedicine, I would not have received medical care for this problem.  
 strongly disagree     disagree     undecided     agree     strongly agree

