

**Telemedicine Questionnaire**  
**(Check all that apply)**

Physician/Practice Name \_\_\_\_\_ Policy # \_\_\_\_\_

Specialty \_\_\_\_\_ Date Completed \_\_\_\_\_

Physician Attestation:

All of the information below is true and accurate to the best of my knowledge and belief. I understand this Questionnaire is used for underwriting purposes.

Physician Signature: \_\_\_\_\_

Please provide the list of states for which you perform telemedicine and the percentage from each state. Please provide information on any International exposure.

- |                                    |                                    |                                    |                                    |                                    |
|------------------------------------|------------------------------------|------------------------------------|------------------------------------|------------------------------------|
| <input type="checkbox"/> AL _____% | <input type="checkbox"/> HI _____% | <input type="checkbox"/> MA _____% | <input type="checkbox"/> NM _____% | <input type="checkbox"/> SD _____% |
| <input type="checkbox"/> AK _____% | <input type="checkbox"/> ID _____% | <input type="checkbox"/> MI _____% | <input type="checkbox"/> NY _____% | <input type="checkbox"/> TN _____% |
| <input type="checkbox"/> AZ _____% | <input type="checkbox"/> IL _____% | <input type="checkbox"/> MN _____% | <input type="checkbox"/> NC _____% | <input type="checkbox"/> TX _____% |
| <input type="checkbox"/> AR _____% | <input type="checkbox"/> IN _____% | <input type="checkbox"/> MS _____% | <input type="checkbox"/> ND _____% | <input type="checkbox"/> UT _____% |
| <input type="checkbox"/> CA _____% | <input type="checkbox"/> IA _____% | <input type="checkbox"/> MO _____% | <input type="checkbox"/> OH _____% | <input type="checkbox"/> VT _____% |
| <input type="checkbox"/> CO _____% | <input type="checkbox"/> KS _____% | <input type="checkbox"/> MT _____% | <input type="checkbox"/> OK _____% | <input type="checkbox"/> VA _____% |
| <input type="checkbox"/> CT _____% | <input type="checkbox"/> KY _____% | <input type="checkbox"/> NE _____% | <input type="checkbox"/> OR _____% | <input type="checkbox"/> WA _____% |
| <input type="checkbox"/> DE _____% | <input type="checkbox"/> LA _____% | <input type="checkbox"/> NV _____% | <input type="checkbox"/> PA _____% | <input type="checkbox"/> WV _____% |
| <input type="checkbox"/> FL _____% | <input type="checkbox"/> ME _____% | <input type="checkbox"/> NH _____% | <input type="checkbox"/> RI _____% | <input type="checkbox"/> WI _____% |
| <input type="checkbox"/> GA _____% | <input type="checkbox"/> MD _____% | <input type="checkbox"/> NJ _____% | <input type="checkbox"/> SC _____% | <input type="checkbox"/> WY _____% |

Other Countries – Please List: \_\_\_\_\_

What percentage of your total practice is devoted to telemedicine? \_\_\_\_\_ %

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(Check all that apply)**

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**Email**

1. Does your practice engage in electronic communications with patients?  Yes  No

A. If "Yes", is it only through a secure Internet-based communication system (i e. Patient Portal).  Yes  No

B. If "No", **or** if you answered "Yes", but you also use additional technology, (e.g. text messaging), please explain the technology that your practice utilizes.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Is your electronic communication with:

- A.  Established patients only (Defined as registered patients within the context of a patient-physician relationship).
- B.  Prospective patients (Defined as new patients with whom a physician may wish to establish preliminary communications for the purpose of establishing a physician-patient relationship. Electronic communications for such purposes are limited only to setting up an appointment, acquiring preliminary information, such as patient contact information, and basic medical history, or providing basic information about the office visit and with patient understanding that information will only be reviewed when patient attends his/her first appointment).
- C.  Non-patients (Defined as those situations in which the physician provides online medical advice to non-patients, thereby establishing a patient-physician relationship through the exchange of information).

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3. Is electronic communication with patients limited to patients 18 or older?     Yes    No
4. Which of the following transactions do you/the group conduct electronically with patients *(please check all that apply)*
- A. Administrative uses
    - Setting or changing appointments
    - Sending appointment "reminders"
    - Online payment for services
    - Providing directions to practice location
    - Providing practice policies and protocols (e.g. privacy policy, non-insured billing guidelines, etc.)
    - Other (explain below)
  
  - B. Education and health promotion
    - Providing general educational and health promotion electronic documents and resources
    - Providing links to educational and health promotion websites
    - Incorporating health promotion messages
    - Providing links to online self-assessment and help tools
    - Providing guidance to patients regarding health-related websites
    - Newsletters and alerts
    - Community support resources
    - Other (explain below)
  
  - C. Patient care
    - Communicating normal test and/or lab results
    - Answering general, preventative health questions
    - Clarifying or reiterating instructions
    - Providing post-procedure instructions and follow-up
    - Allowing patients to report self-care measurements (e.g. blood pressure readings)
    - Receiving patient requests for prescription refills
    - Notifying or reminding about routine tests and procedures
    - Monitoring
    - Consulting related to conditions that have been previously discussed
    - Addressing/Diagnosing "new" patient complaints/conditions
    - Conducting virtual patient visits
    - Prescribing medication
    - Other (explain below)

**Telemedicine Questionnaire**  
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If "other", what other patient transactions will you be conducting? (Please provide detailed description)

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5. Do you have a written email policy?  **Yes**  **No**

If "Yes", does your email policy include provisions to address at least the following issues: (please check all that apply)

- Situations not appropriate for email - including urgent messages and other messages that require an immediate response; highly sensitive information, such as HIV-related treatment or test results; sex related treatment, or psychiatric or substance abuse treatment along with instructions on what patients are to do in those situations.
- Limitations – including informing patients that email is not to be used to report new complaints or symptoms, or for complicated questions that cannot be answered quickly and simply; and instead referring patients for an office visit.
- Triageing of messages - including whether physicians will read all incoming emails or whether a member of the staff will perform that triage and route them to the appropriate physician for response, and informing patients of this procedure in receipt of e-mails.
- Response time to messages, including established turnaround time for responding to messages.
- "Allowable" email topics - including clear delineation of what content is prohibited (e.g. highly sensitive patient information or legal matters).
- Confidentiality and privacy issues – emphasizing that confidentiality cannot be guaranteed, and that all email communication, whether incoming or outgoing, will be made part of the medical record.

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Informed consent/user agreement documenting each patient's understanding and agreement to the permitted use and limitations of the portal.

6. Does your system meet HIPAA privacy and security rules?  **Yes**  **No**

7. Are you/will you engage in any medically-related commercial activity on the internet?  **Yes**  **No**

A. If "Yes", please explain in detail:

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8. Are you/will you be posting all email correspondence (sent and received) to the patient record?  **Yes**  **No**

**Video and Audio-based Patient Interaction**

9. Prior to any patient interaction, you ensure that the patient is physically located in a jurisdiction in which you are duly licensed and credentialed.  **Yes**  **No**

10. Prior to any patient interaction, patients are informed that the telemedicine visit provides the same doctor-patient relationship as an in-person visit.  **Yes**  **No**

11. You/your practice observe all federal, state and local requirements governing the definition and practice of telemedicine. (Note, for example that providers and healthcare entities should be aware that audio-only communication –i.e. phones – may not fall under the definition of "telemedicine" under some current or pending state statutes or legislation.)  **Yes**  **No**

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12. You/your practice understands that a provider-patient relationship may be established through video or telephonic means for conditions amenable to the respective mode of care once the patient agrees to be treated and the provider agrees to diagnose and treat the patient.  **Yes**  **No**

It is further understood that this relationship obligates you/your practice to perform the following actions prior to commencement of care:

- A. Obtain verification of the patient's location  **Yes**  **No**
- B. Disclose the provider's identity and credentials  **Yes**  **No**
- C. Obtain required consents and acknowledgements from patients  **Yes**  **No**

13. Telephonic-only evaluation and treatment is performed only to patients who are known to the practice, those with whom the provider(s) have a pre-established provider-patient relationship, or to patients located in rural or remote areas when this would be the only patient care option and care would otherwise be unavailable.  **Yes**  **No**

14. In situations when telephone evaluation is based on patient history, clinical histories include a record of patient symptomatology organized in a format that assists in developing a diagnosis and treatment plan and includes the following components:  **Yes**  **No**

- A. Identifying information  **Yes**  **No**
- B. Source of history  **Yes**  **No**
- C. Chief complaint(s)  **Yes**  **No**
- D. History of present illness  **Yes**  **No**
- E. Associated signs and symptoms  **Yes**  **No**
- F. Past medical history  **Yes**  **No**
- G. Family history  **Yes**  **No**
- H. Personal and social history  **Yes**  **No**
- I. Medication review  **Yes**  **No**
- J. Allergies  **Yes**  **No**
- K. Detailed review of symptoms  **Yes**  **No**
- L. Provider-directed patient self-examination, as appropriate  **Yes**  **No**

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- 15. Virtual physical exams (for video or telephone-based visits) are performed by you/your practice as indicated by the patient complaint, the history and conditions reported by the patient using available technology, which comport with the standard of medical care and provider training, and are comparable to in-person, face-to-face care.  **Yes**  **No**
  
- 16. Documentation is performed following each patient encounter and is maintained in a secure, HIPAA compliant format and location.  **Yes**  **No**
  
- 17. Following every visit, providers communicate results of patient encounters to patients' primary care provider or other specialty providers using secure methods (e.g., fax, secure email, transmit to EHR) as well as to the patient, unless the patient has requested a limitation on such communication.  **Yes**  **No**
  
- 18. Appropriate disposition is discussed with all patients, including any required follow-up and discussion of clinical signs that would signify a required escalation of the clinical problem.  **Yes**  **No**
  
- 19. Laboratory tests, including any diagnostics ordered in the usual course of patient evaluation via phone or video-based management, are routinely followed up in a timely manner with patients and any additional care providers as needed.  **Yes**  **No**
  
- 20. You/your practice have developed and implemented protocols for the delivery of care for conditions the entity can treat following established evidence-based/peer-reviewed standards for treatment by telemedicine. In general, guidelines include at a minimum the following components  **Yes**  **No**
  - A. Named condition and corresponding ICD code.  **Yes**  **No**
  - B. Scope of condition amenable to treatment by telemedicine based a peer-reviewed guideline or expert opinion.  **Yes**  **No**
  - C. The mode of intervention required to treat the condition (i.e., is telephonic care adequate or is VTC required?)  **Yes**  **No**
  - D. Documentation required to appropriately assess the patient's condition including history, video-based examination (including required components needed to visualize, demonstrate or test)  **Yes**  **No**
  - E. Parameters under which the condition can be treated  **Yes**  **No**
  - F. Parameters under which the condition may not be treated and require referral to alternate modes of medical management.  **Yes**  **No**

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21. You/your practice have developed and implemented policies for communication and sharing of medical records with Primary Care Providers and other appropriate entities that conform to HIPAA, HITECH (Health Information Technology for Economic and Clinical Health Act) and other applicable laws that comply with industry best practices.  **Yes**  **No**
- A. Policies include appropriate disclosure to patients about sharing their personal healthcare information (PHI).  
 **Yes**  **No**
22. All efforts have been taken to make audio and video transmission secure by using point-to-point encryption that meets recognized standards. *Note that as of May, 2014 FIPS 140-2, known as the Federal Information Processing Standard, is the US Government security standard used to accredit encryption standards of software and lists encryption such as AES (Advanced Encryption Standard) as providing accepted levels of security.*  **Yes**  **No**
23. You/your practice have developed and implemented policies for the use of mobile devices that includes:
- A. Passphrase or equivalent security feature before the device can be accessed  **Yes**  **No**
- B. Requirement that phones be kept in the possession of users at all times  **Yes**  **No**
- C. Provider ability to remotely disable or wipe their mobile device in the event it is lost or stolen  **Yes**  **No**
24. In the event of a technology breakdown during videoconferencing, causing a disruption of the session, you/your practice have a backup procedure in place that is communicated to the patient prior to commencement of treatment.  **Yes**  **No**