Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. I understand that my health care provider wishes me to engage in a telemedicine consultation.
2. My health care provider has explained to me how video conferencing technology will be used to affect such a consultation. It will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.
3. I understand there are potential risks to this technology, including interruptions access and

technical difficulties. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that videoconferencing connections are not adequate for the situation.

1. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my health care provider in order to operate the video equipment. I will be informed of their presence in the consultation and thus retain the right to request the following: (1) omit specific details of my medical history/physical examination that are personal to me;

(2) as non-medical personnel to leave the telemedicine examination room: (3) terminate the consultation at any time.

1. I have had alternatives to a telemedicine consultation explained to me, and in choosing to participate in a telemedicine consultation. I understand that some parts of the exam involving physical tests may need to be conducted at my location at the direction of the care provider. Furthermore, some necessary physical or diagnostic testing may need to be conducted in person at the specialist’s location.
2. In an emergent consultation, I understand that the responsibility of the telemedicine consulting specialist is to advise me or my local practitioner and that the specialist’s responsibility will conclude upon the termination of the video conference connection.
3. I understand that my practitioner’s office will take payment before the appointment.
4. I have a direct conversation with my doctor, during which I have the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

By signing this form, I certify:

* That I have read or had this form read to me and /or had this form explained to me
* That I fully understand its contents including the risks & benefits of this (these) encounter(s)
* That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

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

Patient’s/ parent/guardian signature Date Time

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

Witness signature Date Time