Informed Consent to Telemedicine Consultation

PATIENT NAME: ________________________________ Date of Birth __ / ___ / ______

PURPOSE: The purpose of this form is to obtain my consent to participate in telemedicine consultation with provider(s) at SUPARNA CHHIBBER MD PA (dba : Houston Family and Geriatric Medicine), herein after *Office*

I understand the following:

1. The telemedicine consult is done through a two-way video link-up whereby the physician or other health provider at the *Office* can see my image on the screen and hear my voice. However, unlike a traditional medical consult, the physician or other health provider does not have the use of the other senses such as touch or smell; and it may not be equal to a face-to-face visit.
2. Since the telemedicine consultants are in a different location and do not have the opportunity to meet with me face-to-face, they must rely on information provided by me. The providers cannot be responsible for advice, recommendations and/or decisions based on incomplete or inaccurate information provided by me.
3. I can ask questions and seek clarification of the procedures and telemedicine technology.
4. I can ask that the telemedicine exam and/or videoconference be stopped at any time.
5. I know there are potential risks with the use of this new technology. These include but are not limited to:
    - Interruption of the audio/video link.
    - Disconnection of the audio/video link
    - A picture that is not clear enough to meet the needs of the consultation
    - Electronic tampering. If any of these risks occur, the procedure might need to be stopped.
6. The consultation may be viewed by medical and technical persons for evaluation, informational, quality, or technical purposes.

I, the undersigned patient, do hereby understand and state that I agree to the above consents. I have read it and I understand and agree to its contents. I volunteer to participate in the telemedicine examination. I authorize *Office* and the doctors, nurses, and other providers involved to perform procedures that may be necessary for my current medical condition.

Date: ______________________________ Time:_____________________ am/pm

Signature:___________________________ Printed Name:__________________

Version: 1.0