TELEHEALTH CONSENT

1. I understand that my health care provider wishes me to engage in a telemedicine consultation using Doxy.me.

2. My health care provider has explained to me how the Doxy.me video conferencing technology will be used to affect such a consultation 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, unauthorized access and technical difficulties. I understand that my healthcare provider or I can discontinue the telemedicine consult/visit if it is felt that the Doxy.me videoconferencing connections are not adequate for the situation.

4. I understand that if others are present during the consultation other than my health care provider, they will maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room: and or (3) terminate the consultation at any time.

5. I understand that this visit and evaluation and management will be conducted through telemedicine and billed following Medicare guidelines. I am aware and understand that I may be responsible for some or all of the visit charges if my insurance deems this "noncovered."

By signing this form, I certify that I have read the above and fully understand its contents.

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Patient Signature Date