



Consent to Telemedicine Services/HIPAA Acknowledgement

The purpose of this informed consent form is to obtain your consent to receive telemedicine health care services from us through the AthenaHealth Electronic Health Record and Simple Visit Telehealth vendor. Athena and Simple Visit allow our health care personnel to communicate with you in real time. Communications via Athena and Simple Visit may include, but are not limited to, appointment scheduling and a video consultation with our health care personnel.

The benefits of a video consultation (i.e., telemedicine) to you may include: 1. Reducing waiting times. 2. Avoiding any need for you to travel to our locations.

The risks of a video consultation may include: 1. The consultation may not be exactly the same as or as complete as a face-to-face visit. 2. Technical problems could cause interruptions or require us to reschedule your visit. 3. The potential for security risks, including hacking or tapping into the visit by outsiders. However, due to security precautions, we believe the risk is small.

As an alternative to the video consultation you may schedule an in-person office visit with us, but you will have to travel to our location. You may stop using the video consultations at any time, including in the middle of a visit, and if you would like, schedule a visit at our location.

All existing laws pertaining to the privacy of your health information apply to the video consultation. We may share or disclose your health information consistent with our Notice of Privacy Practices, including to your referring physician for treatment or coordination of care and to your insurance company for payment purposes.

Dr. Ann Liebeskind will be the physician primarily conducting the telemedicine consultation. Other staff members and health care personnel may be present during the video consultation, including, but not limited to, a dietician or exercise physiologist. If you do not wish for any other staff members to be present, you may ask them to leave the room at any time.

By signing below, I acknowledge that:

I have read this document carefully and understand the risks, benefits and alternatives discussed on the prior page to the use of a video consultation for my health care services.

My health care provider has explained to me how the video conferencing technology will work and that he or she may discontinue the consultation if the connections are not working adequately. I understand that my health care provider determines whether or not the condition being diagnosed or treated is appropriate for a telemedicine encounter.

I have been given an opportunity to ask questions and all of my questions have been adequately addressed. I voluntarily and freely give my consent to take part in the telemedicine service.

I AGREE TO HOLD CORAGGIO LLC DBA MOBILE HEALTH TEAM AND MY HEALTH CARE PROVIDER HARMLESS FROM ANY AND ALL DAMAGES RESULTING FROM INFORMATION LOST DUE TO TECHNICAL FAILURES OCCURING DURING THE VIDEO TELECONFERENCING.

Signature of Patient or Legal Representative Witness

Patient Name _____