SUNRISE NEUROLOGY P.A.

PATIENT'S NAME:

_____DOB:_____

1. **Purpose:** The Purpose of this form is to obtain your consent to participate in telemedicine for the following services: Provide clinical services.

2. **Telemedicine in General:** Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. The information may be used for diagnosis, therapy, follow-up and /or education, and may include any of the following:

    - Live two-way audio and video
    - Medical Images
    - Patient Medical records
    - Output data from medical devices and sound and video files

3. **Expected Benefits:**

    - Improved access to health care by enabling a patient to remain at home (or at a remote site) while receiving care from a distance.

4. **Potential Risks:** Risks include but are not limited to:

    - In the event of interruption or disconnection of the audio/video connection, the continuity or completion of a telemedicine visit will depend upon whether the information transmitted is sufficient for the patient's condition. If the audio/video connection is inadequate for the purpose or is disconnected, SUNRISE NEUROLOGY PA may require an in-person visit. Your health information will be transmitted electronically by audio and video. The security and confidentiality of information transmitted electronically may be compromised by the failure of security safeguards or illegal or improper tampering.

    - While SUNRISE NEUROLOGY PA has taken reasonable and appropriate efforts to eliminate any confidentiality risks associated with your telemedicine appointment, SUNRISE NEUROLOGY PA cannot control your

environment or any company you may have during the telemedicine appointment.

5. **Nature of Telemedicine:**

    - During the telemedicine appointment, details of your medical history and current condition may be discussed by interactive audio/video technology. SUNRISE NEUROLOGY PA and its providers rely on information by you and it is your responsibility to provide information about your medical history, condition, and care that in complete and accurate to the best of your ability. SUNRISE NEUROLOGY PA and its providers' advice, recommendations, and decisions may be based on factors not within their control, such as incomplete or inaccurate data provided by you or distortions of audio/video during the telemedicine visit.

    - SUNRISE NEUROLOGY PA has the right to determine if a telemedicine appointment is appropriate for your needs and may recommend an in-person appointment.

6. **Medical Records:** All existing laws regarding your access to medical information and copies of your medical records apply to this telemedicine visit. Your provider will document the medical information conveyed during the appointment into your medical record the same as if it were an in-person visit. Please note, not all telecommunications are recorded and stored.

7. **Payment Agreement:** By signing below you understand that your insurance will be billed for any telemedicine services you receive from SUNRISE NEUROLOGY PA; you may be billed for what your insurance does not cover, including any deductibles, coinsurance and copay; and you have been advised to check with your insurance carrier for coverage of telemedicine visits. If your insurer does not cover telemedicine visits, then you will be responsible for the full fees for telemedicine services you received from SUNRISE NEUROLOGY PA.

8. **Data and Devices:** SUNRISE NEUROLOGY PA does not warrant that its telemedicine services will be compatible with any updates to, or prior versions of, your devices' operating systems. To the extent that your telemedicine appointment requires the use of wireless, cellular data, or internet access, you are responsible for securing the necessary data access service. E.g. your mobile phone provider may charge you data access fees in connection with your use of telemedicine services. You are solely responsible for all such charges payable to third parties.

9. **Patient Rights:** You may withhold or withdraw your consent to telemedicine at any time without affecting your right to future care or treatment.

By signing this form, I understand the following:

1. I have been advised of the potential risks, consequences, and benefits of telemedicine
2. I have had an opportunity to ask questions about the information presented on this form
3. All my questions have been answered and I understand the information provided above.

My signature below (or other written acknowledgement of my acceptance to the terms above) indicates my consent to participate in a telemedicine appointment in connection with the service (s) described above. The consent will be documented in my medical record with SUNRISE NEUROLOGY PA.

_____ _____

PATIENT'S SIGNATURE DATE