MODERN PODIATRY

# Telemedicine Patient Consent Form

Patient Name:_____ Date of Birth:_____

1. The purpose of this form is to obtain your consent to participate in a telemedicine consultation for the following concern(s) _____

   _____

   _____

2. During the telemedicine consultation:
   a. A non-medical technician may be present in the telemedicine studio to aid in the video transmission.
   b. Video, audio and/or photo recordings may be taken of you during the procedure(s) or service(s).
3. Medical Information & Records: All existing laws regarding your access to medical information and copies of our medical records apply to this telemedicine consultation. The call is not recorded, but a series of images may be captured for documentation purpose. Additionally, dissemination of any patients-identifiable images or information for this telemedicine interaction to other entities shall not occur without your consent.
4. Confidentiality: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation, and all existing confidentiality protections under federal and New Jersey law apply to information disclosed during this telemedicine consultation.
5. Rights: You may withhold or withdraw consent to the telemedicine consultation at any time without affecting your rights to future care or treatment or risking the loss or withdrawal of any programs benefits to which you would otherwise be entitled.
6. Risks, Consequences & Benefits: You have been advised of all the potential risks, consequences and benefits to telemedicine. Your health care practitioner has discussed with you the information provided above. You have had the opportunity to ask questions about the information presented on this form and the telemedicine consultation. All your questions have been answered, and you understand the written information provided above.
7. In addition, I understand that:
   a. The online consult is solely based on the information provided by me in absence of a physical evaluation. The physician may not be aware of certain facts that may limit or affect his or her assessment or diagnosis of my condition and recommend treatment.
   b. The online consult is very different from a regular face-to-face examination. Accordingly, the diagnosis I will receive is limited and provisional.

c. An online consult is not intended to replace a full medical face-to-face evaluation by a physician.

8. I have received/or previously received a copy of Modern Podiatry's Notice of Privacy Practices.
9. I solely assume the risk of the limitations set forth herein, and I further understand that no warranty or guarantee has been made to me concerning any particular result related to my condition or diagnosis.

Disclaimer and Release

I hereby completely and irrevocably release Modern Podiatry and its' parent and sister corporations and their respective medical staff members, physicians and other health care professionals, insurance providers, administrators, officers, employees and directors (collectively the "Modern Podiatry Parties") of any and all errors and omissions, known or unknown, foreseen or unforeseen, knowingly or unknowingly, as well as all claims, or actions or damages arising from or in connections with the online second opinion consult, conclusions or recommendations provided by Modern Podiatry or its physicians. Furthermore, I agree the released parties have no liability or responsibility for the accuracy or the completeness of the medical information submitted to them or for any errors in its electronic transmission.

I agree to participate in telemedicine consultations for the procedure(s) described above.

Signature:_____

If signed by someone else other than the patient, indicate relationship:_____