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Consent to participate in a telemedicine appointment (2020)

1. I understand that my health care provider wishes me to engage in a telemedicine consultation using Doxy.me and/or iPhone Facetime

2. My health care provider has explained to me how the Doxy.me and/or iPhone Facetime 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 and/or iPhone Facetime 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:

   - Omit specific details of my medical history/physical examination that are personally sensitive to me;
   - Ask non-medical personnel to leave the telemedicine examination room: and or
   - Terminate the consultation at any time.

5. I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a Doxy.me and/or iPhone Facetime telemedicine consultation.

6. I have had a direct conversation with my healthcare provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me
- That I fully understand its contents including the risks and benefits of the procedure(s)

Phone #: ____________________________ iphone or Android

Primary Email Address: ____

Parent/Guardian Signature: ____ Date: _________________________

I am the patient, parent, or guardian of the following patients:

1.____________________________________OP# ________ 2.__________________________________OP#_______

3.____________________________________OP# ________ 4.__________________________________OP#_______