NEUROLOGY&
SLEEP CLINIC PLC.

Consent to Participate in Telemedicine Services

Telemedicine allows health care providers to evaluate, diagnose and treat patients at a distance using telecommunications technology. It requires sharing information to help improve your health care.

This information may be used for diagnosis, therapy, follow-up or education, scheduling and billing purposes. It may include:

- Details of your medical history, examinations and diagnostic test results. These may be communicated by the use of interactive video, audio and telecommunication technology.
- You may receive a physical examination from on-site staff at your visit.
- Video, audio and/or photo recordings may be taken of you during the telemedicine visit and stored in your electronic medical record.
- A technical specialist may be present if needed for communication services.
- Individual involved will be announced and are expected to maintain confidentiality of information obtained and or observed.

Expected benefits

- Improved access to medical care by enabling you to remain at your local health care site (your home, for example) while the health care provider collects and reviews test results at another site, which may be in another state
- More efficient evaluation and management for your medical needs
- Obtaining the expertise of a specialist without having to travel

Possible risks

As with any medical procedure, there are possible risks associated with the use of telemedicine. These risks may include, but are not limited to:

- Medical evaluation or treatment may be delayed because of failure of equipment or technical services and may not be the same as direct patient to provider careas I will not be in te same room as my health care provider.
- The provider may decide the transmitted information is of poor quality, requiring the telemedicine visit to be rescheduled or a face-to-face visit with your local provider be scheduled.
- Security processes could fail, causing a breach in the security of personal information.
- Not having access to your complete medical record may result in adverse drug interactions, allergic reactions or other errors.

I understand my participation in telemedicine is voluntary. I may refuse to participate or decide to end my participation at any time. I understand that my refusal to participate, or my decision to stop participation will be documented in my medical record. I have been informed of the potential consequences of withdrawing my consent to participate in telemedicine services.

I understand providers at the remote site and the local site may have access to relevant clinical information including mental health information, and alcohol and drug abuse information.

I understand Neurology & Sleep Clinic, PLC will use electronic systems that include network and software security protocols to protect my personal health information.

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I have read this document and received information about the process and telemedicine providers. I hereby consent to participate in services using telemedicine under the terms described above. I understand this document will become a part of my medical record.

Please check the appropriate box:

_____I want to participate in and receive services through telemedicine.
_____I do not want to participate in telemedicine sessions, and I understand the consequences.

______________________________________ ______________________________

Patient signature Date

☐ **It has been determined the patient is unable to sign and, with attempt made, a legal guardian or personal representative is not available or accessible.**

☐ **It has been determined the patient is medically unable to give informed consent and a legal guardian or personal representative is available. Please complete:**

The above consent is accepted and given on behalf of: ______________________________ because it has been determined the patient is medically unable to give informed consent.

______________________________________ ______________________________

Legal guardian or personal representative Date

____

Relationship to patient

Check if applicable: ☐ **telephone/verbal consent (witnessed by two staff members)**

______________________________________ ______________________________

Witness Date

______________________________________ ______________________________

Witness Date

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More Info at www.NeurologyandSleepClinic.com