CONSENT TO PARTICIPATE IN TELEMEDICINE CONSULTATION

Purpose: This form is intended to obtain your permission to participate in a telemedicine consultation,

Introduction: Telemedicine is the use of live video conferencing to enable healthcare providers at a different location to provide health care treatment to you and/or consult with you about your healthcare options and decisions, Due to the physician and the patient being in different physical locations, telemedicine consultations are not the same as direct patient/healthcare provider visits. Telemedicine allows Dr Bachar Malek and/or his Nurse Practitioners, and/or LSCW, and/or support staff of Indiana Exceptional Medical Care to provide services to you that may otherwise require you to travel to the office. Consenting to participate in a telemedicine consultation allows the patient to stay in his/her own home.

Possible Risks: By the patient signing this consent, you are acknowledging that you understand the following risks:

* Despite our best efforts to protect the privacy of patient information, security protocol could fail causing a breach of privacy of personal medical information.

* Video, audio, and/or photo recordings may be taken of you during the service.

* Delays in medical evaluation and treatment may occur due to failures of electronic equipment,

* The possibility that any acute complaint may require a face to face encounter at the office. In a rare occurrence that a patient develops an emergent situation, appropriate measures will be implemented including but not limited to: calling 911 for emergency personnel or instructions for patient to go immediately to the emergency department.

Process: By the patient providing his/her verbal consent for signing by proxy, you are acknowledging that you understand the following:

* Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure integrity against intentional and unintentional corruption.

* I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine and that not information obtained in the use of telemedicine, which identified me, will be disclosed to researchers or other entities without my written consent.

* I understand that I have the right to withhold or withdraw my consent to use telemedicine in the course of my care at any time, without affecting my right to future care or treatment.

* I understand the alternatives to telemedicine consultation as they have been explained to me and in choosing to participate in a telemedicine consultation, I understand that some parts of the exam involving physical tests may be conducted by individuals at my location, under the direction of the healthcare provider.

*I understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated and all of my questions have been addressed to my satisfaction.

* I understand that there are potential risks to this technology, including interruption, unauthorized access and technical difficulties. I understand that my healthcare provider or I can discontinue the telemedicine consult/visit if it is felth that video conferencing connections are not adequate for the situation.

* I have had this document explained to me and understand the risks and benefits of the telemedicine consultation and have had my questions regarding the procedure explained to me. I hereby give my informed and verbal consent to participate in a telemedicine consultation under the terms described.

Consent: By verbal agreement, you are consenting to participate in a telemedicine consultation, You are acknowledging that you have been informed of the provisions in this form and understand them. You are acknowledging that your healthcare provider, or such assistants that may be designated, have explained to you how telemedicine video consultations proceed.

*I hereby consent to participate in telemedicine consultation.

Signature of Patient:

Date:

Time:

Distant Site: Indiana Exceptional Medical Care 4972 Lincoln Ave, Suite 101

Evansville,IN 47715

Originating Site (Patient Location Address):