# Consent for Telemedicine

Patient Name: _____ DOB: _____

1. I understand that Ramia Gupta, MD, wishes me to engage in a telemedicine consultation.

2. Ramia Gupta, MD, has explained to me how the video conferencing technology will be used to affect such a consultation which 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 Ramia Gupta, MD, or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

4. I understand that my healthcare information may be shared with other individuals for billing purposes and other legal requirements as stated in Notice of Privacy Practices.

5. I have had the alternatives to a telemedicine consultation explained to me, and I am choosing to participate in a telemedicine consultation.

6. I understand that in an emergent consultation, I understand that the responsibility of the Ramia Gupta, MD, is to contact the emergency services.

7. I understand that billing will occur from Ramia Gupta, MD.

8. I have had a direct conversation with Ramia Gupta, MD, 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.

9. I understand that in order to use the telemedicine service I will share my email address with Ramia Gupta, MD, and that the email will be used to join the telemedicine consult only. I understand that email is not a confidential communication. Furthermore I agree to not communicate any medical concerns, questions, appointment schedules, and HIPPA information by email to Ramia Gupta, MD.

10. I will not record this telemedicine appointment using any kind of recording device.

Email_____

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).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

_____ _____

Patient's/Guardian signature Date