CONSENT TO PARTICIPATE IN A TELEMEDICINE CONSULTATION/TREATMENT

I _____ **[print name of parent/legal guardian]**, authorize and voluntarily consent to the participation and treatment of _____ **[print name of patient]** in a telemedicine consultation and/or treatment with _____ **Rinku Mehra, MD** and other practitioners in The Mehra Clinic, PLLC. If the parent/legal guardian is giving consent, you are doing so because the patient is a minor or has been determined to be incompetent to give medical consent.

1. I understand that as a participating patient/parent/legal guardian, I/we will communicate by interactive videoconferencing technology with physicians and health care professionals at THE MEHRA CLINIC, PLLC.

2. It will be explained to me how the videoconferencing technology will be used. I understand that this visit will not be the same as an in-person visit due to the fact that my child will not be in the same room as the healthcare provider. I also understand that I have the option to see a healthcare provider in person if I choose. I understand that medicine is not an exact science and there are no guarantees that can be made regarding outcomes and results of these examinations and treatments.

3. I understand that either the healthcare provider or I can discontinue my child's telemedicine visit if it is felt that the videoconferencing connections are not adequate for the situation.

4. I understand it may be necessary for others to be present with my healthcare team to operate the video equipment. These individuals are bound to maintain confidentiality. I further understand that I have the right to request the following when nonmedical personnel are present: (1) to omit specific details of my child's medical history/physical examination that are personally sensitive to me; (2) to ask nonmedical personnel to leave the room; and/or (3) to terminate the visit at any time.

5. Any interview, tape, film or photograph made of my child will be used for medical purposes and maintained by THE MEHRA CLINIC, PLLC as confidential medical records, consistent with Federal and State law. THE MEHRA CLINIC, PLLC encrypts data during transmission and stores data in accordance with HIPAA requirements. I acknowledge that risks to privacy exist to data transmitted and stored electronically notwithstanding THE MEHRA CLINIC, PLLC's protective measures. I acknowledge that information may be lost due to technical failures, and I agree to hold THE MEHRA CLINIC, PLLC harmless for such unintentional loss.

6. I understand that THE MEHRA CLINIC, PLLC will not bill my insurance. The Mehra Clinic, PLLC does not participate with any health plans, HMO panels, or any other third-party payor. As such, we may not submit bills or seek reimbursement from any third-party payors for the Services provided under this Agreement.

By signing this consent,

a. I authorize THE MEHRA CLINIC, PLLC to release any and all information about my medical condition to physicians and other health care professionals within THE MEHRA CLINIC, PLLC for evaluation and consultation with my health care professional identified above.

PATIENT FULL LEGAL NAME:

DATE OF BIRTH:

b. I further understand and consent to being interviewed, taped, filmed, or photographed by my physician and/or THE MEHRA CLINIC, PLLC in the course of the visit.
c. I acknowledge that I am at least 18 years old OR I am an authorized parent/legal guardian of the minor for whom I seek health care during the telemedicine visit.
d. I (along with the patient) will at all times during the telemedicine visit be physically located within the Commonwealth of Virginia and be physically situated in a location and an environment that will support privacy and security.
e. I will not use the telemedicine visit in any unlawful way and/or for any unlawful purpose and I will not communicate under a false name or impersonate another person, nor will I misrepresent the identity of the patient, nor will I misrepresent my authorization to act on behalf of others.
f. I will not record or store any of the video consultation on any computer or other device.

7. I understand the following benefits, limitations and risks of telemedicine.

a. The potential benefit includes efficient access to health care from a remote location of my choice (within the Commonwealth of Virginia).
b. The potential limitations and risks include but are not limited to:
    (1) Incomplete, inaccurate, or delayed diagnosis or recommended course of treatment may result from the inability to perform an in-person evaluation;
    (2) Shared information may not be sufficient (e.g. poor resolution of images, audio or video) to allow for appropriate medical decision-making by health care professionals;
    (3) The level of privacy and security of the telemedicine visit depends upon the location and environment that I choose;
    (4) Possible delays in evaluation and treatment due to unexpected telemedicine equipment and/or connection problems may occur; and
    (5) In the event that a health care professional prescribes a medication, s/he will limit the supply based on state regulations and will only prescribe a medication as determined appropriate in his/her sole discretion and professional judgment.

8. I understand the following security and access rules apply.

a. THE MEHRA CLINIC, PLLC considers the telemedicine visit to be a private patient encounter, and the participating health care professional(s) will be located in a private area. I acknowledge and accept sole responsibility for choosing the location and environment from which I will participate. I understand that THE MEHRA CLINIC, PLLC is not responsible for actions at my location.
b. I agree to prohibit anyone else from using my account and credentials, and I agree to immediately notify THE MEHRA CLINIC, PLLC of any actual or suspected unauthorized use of my account or credentials or other security concerns of which I become aware.
c. THE MEHRA CLINIC, PLLC reserves the right to monitor all access to and use of the telemedicine technology and may suspend, deny or end access at any time. If access is denied, I may still choose to seek care inperson at a THE MEHRA CLINIC, PLLC location.

9. I understand that I have the right to withdraw my consent at any time. If at any time I am not satisfied with the services rendered, I may file a complaint with Dr. Mehra.

10. I have read (or have had read to me) this document carefully, and hereby consent to participate in the telemedicine consultation services under the terms described above.

_____ _____ _____

Signature of Person Giving Consent Relationship to Patient Date

PATIENT FULL LEGAL NAME:

DATE OF BIRTH: