Neurological Institute of Northern Virginia
5130 DUKE STREET, SUITE 9
ALEXANDRIA, VA, 22304

TELEMEDICINE PATIENT CONSENT/REFUSAL FORM: FOR NATIONWIDE EMERGENCIES ONLY

PATIENT NAME: _____

DATE OF BIRTH: _____

1. PURPOSE: The purpose of this form is to obtain your consent to participate in telemedicine consultations which includes both phone calls and/or video calls.

2. NATURE OF TELEMEDICINE CONSULT: During the telemedicine consultation:

a. Details of your medical history, examinations, and tests will be discussed with Dr. Sabet through the use of interactive video, audio and telecommunication technology

b. A physical examination of you may take place

c. A non-medical technician may be present in the telemedicine studio to aid in the video transmission

3. MEDICAL INFORMATION & RECORDS: All existing laws regarding your access to medical information and copies of your medical records apply to these telemedicine consultations

4. CONFIDENTIALITY: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation, and all existing confidentiality protections under federal and Virginia state law apply to information disclosed during this telemedicine consultation.

5. RIGHTS: You may withhold or withdraw consent to the telemedicine consultation at any time without affecting your right to future care of treatment.

6. RISKS, CONSEQUENCES & BENEFITS: You have been advised of the potential risks, consequences and benefits of telemedicine. You have had the opportunity to ask questions about the information presented in this form and the telemedicine consultation. All your questions have been answered, and you understand the written information provided above.

☐ **I agree** to participate in telemedicine consultations (including both phone calls and/or video calls) as they arise and I understand that there are limitations to this method of communication which include the absence of a neurological exam. **I understand** that I must be located in either the state of **Virginia or the District of Columbia** at the time of the telemedicine consultation.

OR

☐ **I refuse** to participate in a telemedicine consultation for the procedure(s) described above.

_____	_____	_____/_____/_____
Print Name	**Signature**	**Date**