CONSENT FORM

I understand that telehealth is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and herby consent to Temak to facilitate my Telehealth appointment with their network of independent providers providing health care services via telehealth. **(Providers: Doctor, Physical therapy, License Clinical worker)**

Nature of Telemedicine Consultation: During the telemedicine consultation:

- Details of you and/or your child's medical history, examinations, x-rays, and tests will be discussed through the use of interactive video, audio and telecommunications technology.
- Non-medical technical personnel may be present in the telemedicine studio to aid in video transmission.
- Video, audio, and/or digital photo may be recorded during the telemedicine consultation visit.

Medical Information and Records: All existing laws regarding your access to medical information and copies of your medical records apply to this telemedicine consultation. Additionally, dissemination of any patient-identifiable images or information from this telemedicine interaction to researchers or other entities shall not occur without your consent, unless authorized under existing confidentiality laws.

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telehealth. You will have access to your medical records in accordance to HIPPA.

I understand that all providers on Temak telehealth platform are individual contractors and additional medical record will be kept with the providers

I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care of treatment. I may revoke my consent orally or in writing at any time by contacting Temak Telehealth.

As long as this consent is in force Temak Telehealth network provider may provide me care via telehealth

I understand that telehealth is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider; and herby consent to Temak to facilitate my appointment with their network of independent providers providing health care services via telehealth without the need for me to sign another consent form.

Expected Benefits:

- Improved access to medical care by enabling a patient to seek immediate care for non life treating condition and obtains test results and consults from healthcare practitioners at distant/other sites.
- Obtaining expertise of a distant specialist.

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

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of

images) to allow for appropriate medical decision making by the physician and consultant(s);

- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors;

Confidentiality: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation. All existing confidentiality protections under federal and Georgia State law apply to information disclosed during this telemedicine consultation.

I understand that the Telehealth consult visit is $49.99 for a minimum of 15 minutes and anything over 20 minutes, you may be charged an additional rate of $24.99 for every 10 minutes increment.

I understand that I will be responsible for any service rendered and Temak Telehealth does not bill any insurance provider. I have read and 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 answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

Patient Name: * ____

Location of Patient (City / State): * ______________________________________

Date of Birth: * ______________________________

Patient Signature: * ____________________________

Date * ________________________________