TELEMEDICINE CONSENT

Statement of patient or patient's representative. I certify the following to be true:

1. I have requested a visit with my health care provider.
2. Advanced Menstrual Care Center uses videoconferencing that is HIPAA-compliant.
3. This visit will include both audio and visual capabilities.
4. The appointment will be considered a physician's visit and will be billed to my insurance.

By replying "YES", I acknowledge that I have read and understand this document and am consenting to the telehealth visit.

Patient's Signature:____ Date:________________ Time:____________