TELEMEDICINE INFORMED CONSENT

I hereby request when deemed appropriate by my healthcare provider, but without coercion or duress, to engage in telemedicine through the use of interactive video, audio or other telecommunications technology for my healthcare, understand its limitations, and therefore release David W. Malka, M.D., P.A. dba The M.I.N.D. – The Malka Institute of Neuroscience and Disease, all its affiliated physicians, nurse practitioner, and staff from all liability. I agree to a physical examination of me via telemedicine, and that video, audio, and/or photo recordings may be taken. I hereby certify that have been offered alternatives to telemedicine. I understand there may be potential interruptions, unauthorized access and technical difficulties. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes and that others may also be present during telemedicine in order assist my healthcare provider. I understand that telemedicine may occur with a licensed medical provider who is not licensed in my state. I understand that my health care provider or I can discontinue telemedicine if it is felt not appropriate for the situation. If any unforeseen conditions arise, I do hereby authorize my health care provider, or any assistants designated by my health care provider to take whatever steps and as they deem appropriate. I recognize that my insurance may not cover telemedicine and so I hereby give permission to my health care provider to appeal any insurance denials on my behalf but recognize this as a courtesy, not a requirement. I agree that ultimately all such appeals are my responsibility. I do hereby agree to be personally and promptly responsible for all costs and reimbursements to my health care provider for any and all services rendered to me regardless of any reason for denial, any prior agreements I or my provider have made with my insurer, and whether or not I or my provider feel a service is medically necessary. I certify that I have read or had this form read and/or explained to me, that I fully understand its contents, that I have been given ample opportunity to ask questions, that any questions have been answered to my satisfaction, and that I have been offered a copy of this form.

_____	_____	_____
Patient's/parent/guardian signature	Date of birth	Date of signature

OR

I hereby **refuse** telemedicine as part of my healthcare.

_____	_____	_____
Patient's/parent/guardian signature	Date of birth	Date of signature