1. I understand that I will be participating in an out-patient telemedicine evaluation/examination and diagnosis and treatment.

2. My health care provider has explained to me how the video conferencing technology will be used for the evaluation/examination and will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.

3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties, though using a HIPAA compliant software, . I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes.

5. I have had the alternatives to a telemedicine evaluation/examination explained to me, and in choosing to participate in a telemedicine evaluation.

6. In an emergency situation, I understand that the responsibility of the telemedicine health care provider is to advise my local police department or emergency responders and the telemedicine health care provider will be responsible up to the end of that particular evaluation.

7. I understand that billing will occur from my practitioner or Inland Psychiatric Medical Group, Inc.

8. I have had a direct conversation with my doctor, during which I had the opportunity to ask questions in regard to telemedicine. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

9. I understand the risks of possible but rare breach of HIPAA compliant software and privacy. I understand the risks of delay in treatment due to failure of equipment. Rare but possible drug interactions due to not having access to complete medical records.

Expected Benefits:

1. Better access to healthcare with decrease in wait time
2. Less travel time
3. More non-business hours appointments.
4. Obtaining expertise of a distant specialist
5. More Privacy

By signing this form, I certify: That I have read or had this form read and/or had this form explained to me That I fully understand its contents including the risks and benefits of telemedicine. That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

1. Patient Information

First Name	Middle	Last Name

Date of Birth	Date of Consent

Sign Here

Signature

Date