CAPITAL ALLERGY & RESPIRATORY DISEASE CENTER
A MEDICAL CORPORATION

Consent to Participate in a Telemedicine Appointment

- I understand that my health care provider at Capital Allergy & Respiratory Disease Center (CARDC) may want to engage in a telemedicine consultation using Doxy.me at some point in the future.
- I understand that engaging in a telemedicine consultation 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.
- I understand there are potential risks to this technology including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the Doxy.me video conferencing connections are not adequate for the situation.
- I understand that if others are present during the consultation other than my health care provider, they will maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room: and or (3) to terminate the consultation at any time.
- I have had the alternatives to a telemedicine consultation explained to me, and choose to participate in a Doxy.me telemedicine consultation in the future.
- If during my telemedicine consult, I have an medical emergency, I understand that the telemedicine consultant's responsibility will conclude upon the termination of the Doxy.me video conference connection.
- During my appointment, I will have a direct conversation with my health care provider during which I will receive the opportunity to ask questions in regards to my medical care. Any specific questions regarding my treatment plan will be answered by my healthcare provider and I understand it is my responsibility to follow them.

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 the procedure(s).
- That I have been given ample opportunity to ask questions, and that any questions have been answered to my satisfaction.

Patient/Guardian Signature: _____ Date: _____