Dr. Michael J. Reid/Janel Liverato, P.A.-C
369 Pine Street, Suite 422
San Francisco, CA, 94104

INFORMED CONSENT TO TELEMEDICINE CONSULTATION

I have been asked by my healthcare provider to take part in a telemedicine consultation with the Office of Dr. Michael J. Reid and/or Physician Assistant Janel Liverato.

By initialing the statements below, I acknowledge that I understand the following:

1. The purpose is to assess and treat my medical condition. ____
2. The telemedicine consult is done through a confidential or HIPPA approved two-way video link-up whereby the physician or other healthcare provider at the Office of Dr. Michael J. Reid can see my image on the screen and hear my voice. However, unlike a traditional medical consult, the physician or healthcare provider does not have the use of the other senses such as touch or smell; and it may not be equal to a face-to face-visit. _____
3. Since the telemedicine consultant practice is in a different location and do not have the opportunity to meet with me face-to-face, they must rely on the information provided by me. The Office of Dr. Michael J. Reid can not be responsible for advice, recommendations and/or decisions based on incomplete or inaccurate information provided by me or others. _____
4. I can ask questions and seek clarification of the procedures and telemedicine technology. _____
5. I can ask that telemedicine exam and/or videoconference be stopped at any time. _____
6. I know there are potential risks with this new technology and it can include any of the following: Interruption of the audio/video link, disconnection of the audio/video link, a picture that is not clear enough to meet the needs of the consultation and/or electronic tampering. If any of these risks occur the procedure can be stopped. _____
7. The consultation may be viewed by medical and non-medical persons for evaluation, informational, research, educational, quality or technical purposes. _____
8. I understand the examination may be videotaped or review as might be required by my health coverage plan, however the video images will be used only for those purposes. _____
9. I understand I can make a complaint to the management of the Office of Dr. Michael J. Reid.

I, undersigned patient, do herby understand and state that I agree to the above consents that I have initialed as “agree” and I do not agree to any that I have initialed as “decline”. □_____ **AGREE** □_____ **DECLINE**

I certify that this form has been fully explained to me. I have read it. I understand and agree to its contents. I volunteer to participate in the telemedicine examination. I authorize the Office of Dr. Michael J. Reid and the doctors, and other medical providers involved to perform procedures that may be necessary for my current medical condition.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of medical benefits to Dr. Michael J Reid for medical services rendered and know that I am financially responsible for any balance not covered by my insurance.

Date: _____ **Time: _____ A.M. / P.M.**

Signature: _____ **Printed Name: _____**