New Jersey Vision Associates, P.C.
Mitchell Vogel, M.D., F.A.C.S.
124 Gregory Avenue, Suite 104, Passaic, NJ 07055

Patient Name: _____ **Medical Record No:** _____

1. I understand that my health care provider wishes me to engage in a telemedicine consultation.
2. My health care provider has explained to me how the video conferencing technology will be used to perform a consultation. It will not be the same as a direct patient/health care provider visit since 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. 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. Others may also be present during the consultation other than my health care provider and consulting health care provider to operate the video equipment. The people mentioned above will all maintain the 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) terminate the consultation at any time.
5. I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a telemedicine consultation. I understand that individuals may conduct some parts of the exam involving physical tests at my location at the direction of the consulting health care provider.
6. In an emergent consultation, I understand that the responsibility of the telemedicine consulting specialist is to advise my local practitioner and that the specialist's responsibility will conclude upon the termination of the video conference connection.
7. I understand that billing will occur from both my practitioner and as a facility fee from the site from which I am presented.
8. I have had a direct conversation with my doctor, during which I had the opportunity to ask questions regarding this procedure. 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.

By signing this form, I certify:

I have read or had this form read and/or had this form explained to me.
I fully understand its contents, including the risks and benefits of the procedure(s).
I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

_____ _____ _____

Patient's/Parent/Guardian Signature **Date** **Time**

_____ _____ _____

Witness Signature **Date** **Time**