285 Boulevard NE · Suite 610 · Atlanta, GA 30312
Effective 10/18/19 we are MOVING up to Suite 610, same building

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Midtown Neurology Telemedicine Informed Consent Form

Telemedicine services involve the use of interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
2. I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room.
3. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
   a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
4. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
   a. I may revoke my refusal at any time by contacting **Midtown Neurology @ 404-653-0039.**
5. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
   a. I understand that my insurance carrier will have access to my medical records for quality review/audit.
   b. I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit.
   c. I understand that health plan payment policies for telemedicine visits may be different from policies for in- person visits.
7. I understand that this document will become a part of my medical record.
8. Telemedicine visits may be performed with the originating site at my location, and the distant site at Midtown Neurology, PC. Verbal consent to participate in video visits will also be obtained. These visits are occurring during the Coronavirus (COVID-19) Public Health Emergency. I understand that during my visit, my provider will explain the nature of our telemedicine visits, that:
   a. He/she will evaluate and recommend diagnostics and treatment based on assessment
   b. Telemedicine sessions are not recorded and that my personal health information is protected
   c. Midtown Neurology, PC will provide follow up care to me when it is due.

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand; and (3) am located in the state of Georgia and will be in Georgia during my telemedicine visit(s).

______________________________ ______________________________

Patient/Parent/Guardian Printed Name   Patient/Parent/Guardian Signature

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Date

Original