**B VIRTUAL CARE & WELLNESS LLC’S TELEMEDICINE INFORMED CONSENT**

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SSN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By signing this form, I understand the following:

1. I understand that telemedicine is the use of electronic information and communication technologies by a healthcare provider used to deliver services to an individual when he/she is located at a different location or site than I am (“TeleHealth/Telemedicine”).
2. I understand that I have the right to withhold/withdraw my consent to the use of TeleHealth/Telemedicine at any time, without effecting my right to future care or treatment.
3. I understand that I have the right to inspect all information obtained and recorded in the course of a TeleHealth/Telemedicine interaction, and may receive copies of this information in accordance with Florida law.
4. I understand that electronic communication allows, at a minimum, the use of audio and video equipment for two-way, real time interactive communication between myself (at the school/originating site) and the healthcare provider (at the remote/distant site).
5. I understand that as with any medical procedure, there are expected benefits and potential risks associated with the use of TeleHealth/Telemedicine that I need to be aware of. Possible Risks include, but are not limited to:
   1. As with any healthcare providers, despite reasonable safeguarding efforts, the transmission of my medical information could be disrupted or distorted by technical failures resulting in delays in evaluation or access by unauthorized persons.
   2. As with any healthcare providers, TeleHealth/Telemedicine based services may not be as complete as the you would prefer.
   3. As with any healthcare providers, in rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate decision making by the TeleHealth/Telemedicine healthcare provider.
   4. As with any healthcare providers, in rare instances, security protocols could fail, causing a breach of privacy of personal medical information.
   5. As with any healthcare providers, in rare cases, a lack of access to complete and/or accurate medical records or information may result in adverse drug reactions, allergic reaction, or other judgment error.
6. I understand that by signing this form that I am consenting to receive health care services via TeleHealth/Telemedicine.

I have read and understand the information provided above regarding TeleHealth/Telemedicine and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of TeleHealth/Telemedicine.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_