VerityMD Inc. | Neurology Clinic Consent to Use Telemedicine

Patient's Name: _____
Provider's Name: _____

CONSENT TO USE TELEMEDICINE

I am physically located in **California**. At the beginning of each telemedicine session, I will verify my **full name, current location, readiness to proceed, and ability to engage in a private, uninterrupted consultation.**

By signing this consent, I acknowledge and agree to the following:

1. **Licensure & Limitations:** My provider is licensed to practice in California. If I am outside of California, my provider may be unable to prescribe medications or assist in emergencies. In case of an emergency, I will call **911** or proceed to the nearest emergency room.
2. **Legal Jurisdiction:** I submit to the exclusive jurisdiction of **California state superior courts** for any claims or legal matters related to telemedicine services. This consent is governed by the laws of California.
3. **Appropriateness of Telemedicine:** My provider has determined that telemedicine is suitable for my condition. While I may benefit from this service, **no specific outcomes are guaranteed.**
4. **Transition to In-Person Care:** If my provider determines that an in-person visit is necessary, I agree to either **schedule an in-person appointment** or seek care from a local healthcare provider.
5. **Right to Withdraw Consent:** I may withdraw my consent at any time and choose to receive in-person care instead.
6. **Technology & Limitations:** I understand how electronic communication technology will be used for telemedicine services and acknowledge its limitations. If technical issues arise, an in-person visit may be required.
7. **Personal Responsibility for Telehealth Setup:** I agree to use a **computer, smartphone, or tablet with internet access, a camera, and a microphone** for my telemedicine visits. I will ensure I am in a **private, well-lit, and quiet environment** free from distractions.

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8. **Privacy & Confidentiality:** My telemedicine visits are **HIPAA-compliant**, and my medical information will be **encrypted and securely stored**. No personally identifiable information will be shared unless required by **federal or state law**.
9. **Patient Responsibility for Security:** I understand that using **public or shared computers, allowing devices to save passwords, or transmitting information without encryption** increases my risk of a privacy violation. I am responsible for safeguarding my information.
10. **Recording Consent:** I agree to be videotaped and recorded during the telemedicine services. I understand the resulting images and audio will become part of my medical record.
11. **Access to Medical Records:** I have the right to access my medical records in accordance with **California law**.
12. **Billing & Insurance:** I understand that my telemedicine services will be billed to my insurance, and I am responsible for any copays, deductibles, or other charges as per my policy.

I have read and understand this **Consent to Use Telemedicine**. I have had an opportunity to ask questions, and all of my concerns have been addressed.

Date: _____
Patient's Signature: _____

VerityMD Inc. | Neurology Clinic
5841 Jameson Court, Suite 2, Carmichael, CA 95608
(916) 500-4989 | (916) 244-3875
www.veritymd.com