Saumil Mehta MD PLLC
6404 International Pkwy, Suite # 1010, Plano, TX 75093
Phone # 972-267-1988
Fax # 972-267-3434

INFORMED CONSENT FOR TELEMEDICINE

Date : _____

Patient Name : _____ DOB : _____

1. PURPOSE: The purpose of this form is to obtain your consent to participate in a telemedicine consultation in connection with the medical and mental health service(s) provided by Psychiatric Medical Associates, PA

2. NATURE OF TELEMEDICINE CONSULT: During the telemedicine consultation:

a) Details of your medical history, examinations, x-rays and labs will be discussed with other health professionals through the use of interactive video, audio, and telecommunication technology.

b) A physical examination of you may take place.

c) A non-medical technician may be present in the telemedicine studio to aid in the video transmission.

d) Video, audio and/or photo recordings may be taken of you during the procedure(s) or service(s)

3. MEDICAL INFORMATION & RECORDS: All existing laws regarding your access to medical information and copies of your medical records apply to this telemedicine consultation. Please note, not all telecommunications are recorded and stored. Additionally, dissemination of any patient-identifiable images or information for this telemedicine interaction to researchers or other entities shall not occur without your consent.

4. CONFIDENTIALITY: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation, and all existing confidentiality protections under federal and Texas state law apply to information disclosed during this telemedicine consultation.

5. RIGHTS: You may withhold or withdraw consent to the telemedicine consultation at any time without affecting your right to future care or treatment.

6. DISPUTES: You agree that any dispute arriving from the telemedicine consult will be resolved in Texas , and that Texas law shall apply to all disputes.

7. PAYMENT OF SERVICES: You agree that Exult Healthcare reserves the right to bill a telemedicine visit to your respective insurance company. As well, you are responsible for any patient portion of the telemedicine consult, before your telemedicine consult will be scheduled.

Please initial after reading this page:_____

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8. RISKS, CONSEQUENCES & BENEFITS: You have been advised of all the potential risks, consequences and benefits of telemedicine. Your health care practitioner has discussed with you the information provided above. You have had the opportunity to ask questions about the information presented on this form and the telemedicine consultation. All your questions have been answered, and you understand the written information provided above.

I agree to participate and give my consent for telemedicine consultations for medical and psychiatric care provided by all providers of Psychiatric Medical Associates, PA. I also hereby authorize Psychiatric Medical Associates, PA to keep the following credit card on file and charge it for balances due for services rendered that my insurance company identifies as my financial responsibility, including but not limited to copay, co-insurance or deductibles.

I authorize Psychiatric Medical Associates, P.A. to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

☐ Visa ☐ Mastercard ☐ Discover ☐ American Express

Credit Card Number _____

Expiration Date _____ / _____ CVV # (Security code on back of card) _____

Cardholder Name _____

Billing Address _____

City _____ State_____ Zip _____

Signature :_____

I have read, understood, and agreed to the policy listed above for Psychiatric Medical Associates, P.A.

_____ _____
Signature of patient / guardian Date

_____
Name of patient / guardian

Please initial after reading this page:_____