PATIENT INFORMED CONSENT FORM
TELEHEALTH VIRTUAL VISIT

This form is for you as the patient to understand the advantages as well as risks in participating in a Video Consultation.

I understand that the benefits of having a video consultation can be:

- A reduced waiting time for me to see my physician.
- Avoiding the need for me to travel to my physician or medical care facility.
- Assisting my physician in improving my medical care.

I understand that I might not get all these benefits. The risks of having a video consultation can be that:

- Video consultation will not be the same as a face-to- face service and may not be as complete.
- There could be technical problems that affect the video visit.
- Although this healthcare service uses systems that meet recommended standards to protect the privacy and security of the video visits, the service cannot guarantee total protection against hacking or tapping into the video visit by outsiders. This risk is small, but it does exist.

If the virtual visit does not achieve everything that is needed, then I will be given a choice about what to do next. This could include a follow-up face-to-face visit, or a second video visit. I can change my mind and stop using video consultations at any time, including in the middle of a video visit. This will not make any difference to my right to ask for and receive healthcare.

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telehealth.
2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that I have the right to inspect all information obtained in the course of a telehealth interaction and may receive copies of this information for a reasonable fee.
4. I understand my obligations for payment of a telehealth visit.
5. I understand that telehealth may involve electronic communication of my personal medical information to other medical practitioners.
6. I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.

I agree to have video consultations with Physicians at Arcis Healthcare, LLC

Name of Patient: _____ Date of Birth: _____
Parent's Name: _____
Signature:_____ Date: _____
