Consent to Contact and Telemedicine Consent

I understand that telemedicine is the use of electronic technology for communication to provide healthcare services wherever the doctor and the patient are located in different locations.

I understand that I CARE PSYCH is based in Florida and likewise uses telemedicine to conduct consultation with its patients.

I understand that with telemedicine, the interaction shall be done through real-time audio-video communication.

I understand that the laws that protect privacy and confidentiality, as well as the confidentiality of medical information through the Health Insurance Portability and Accountability Act (HIPPA), also apply to telemedicine.

I understand that I will be responsible for any payments or coinsurances that apply to my telemedicine visit.

I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment; I have the right to access my information and to inspect my medical information that was transmitted through telemedicine; I have the right to privacy where it shall be necessary to seek my consent in order to disclose my information unless those that are permitted by law to disclose without the need of my consent.

I understand any lawsuit airing out of this agreement or service shall be brought to the courts of the state of Florida, to the exclusion of other states.

COMMUNICATION: Phone, Email, SMS, and Voice mail

I agree to be contacted by CARE clinics for various reasons, including appointment reminders and all business pertaining to your medical care with I CARE PSYCH.

All points above are included and understood:

I authorize the I CARE PSYCH.

To provide me with their diagnosis, observations, and recommendations regarding my condition through telemedicine or over the phone.

I authorize the I CARE PSYCH to contact me on through phone calls. SMS and email.

I authorize CARE PSYCH to leave a voice mail on my phone number provided to them.

Whenever necessary, I authorize the I CARE PSYCH to consult with other physicians or specialists whom they believe to have complete knowledge and skills that can address my case.

I have read and understood the information provided above, my rights, and my obligations regarding telemedicine. I had the opportunity to ask questions, all of which were answered to my satisfaction. Therefore, I now, and from this moment forward, until I provide in writing that I am revoking my

permission, give my consent to the use of telemedicine for medical care. This also includes the use of phones, SMS, and email.

Patient Name Printed ____

Patient Signature ____

Date ___/___/____

Witness or Staff ____

Witness Name Printed______________________________________

Date ___/___/_________