



104 S White Street, Ste 140
Wake Forest, NC 27587
Telephone: (919) 679 - 1880
Fax: (888) 315-7712

Informed Consent for Telehealth Services

Telehealth involves the use of electronic communications to enable healthcare providers at different locations to share individual patient medical information for the purpose of improving patient care. Telehealth services offered by LoginClinics may also include chart review, remote prescribing, appointment scheduling, health information sharing, and non-clinical services, such as patient education. The information you provide may be used for diagnosis, therapy, follow-up and/or patient education, and may include any combination of the following: (1) health records and test results; (2) images and asynchronous communications; (3) live two-way audio and video; (4) interactive audio with store and forward; and (5) output data from medical devices and sound and video files.

The electronic communication systems we use will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

LoginClinics providers (our “Providers”) are an addition to, and not a replacement for, your primary care physician. Responsibility for your overall medical care should remain with your local primary care doctor, if you have one, and we strongly encourage you to locate one if you do not.

Expected Benefits:

- Improved access to care by enabling you to remain in your home while the Provider consults and obtains test results at distant/other sites.
- More efficient care evaluation and management.
- Obtaining expertise of a specialist as appropriate.

Possible Risks:

- Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment and technologies.
- In rare events, our Provider may determine that the transmitted information is of inadequate quality, thus necessitating a rescheduled telehealth consult or a meeting with your local primary care doctor.
- In very rare events, security protocols could fail, causing a breach of privacy of personal medical information.

- In rare events, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors.

If you need to receive follow-up care, assistance in the event of an adverse reaction to the treatment, or in the event of an inability to communicate as a result of a technological or equipment failure, please contact LoginClinics at 919-679-1880 or admin@LoginClinics.com

By signing this "Informed Consent", you acknowledge that you understand and agree with the following:

- I hereby consent to receiving LoginClinics' services via telehealth technologies. I understand that LoginClinics and its Providers offer telehealth-based medical services, but that these services do not replace the relationship between me and my primary care doctor. I also understand it is up to the Provider to determine whether or not my specific clinical needs are appropriate for a telehealth encounter.
- I have been given an opportunity to select a Provider from LoginClinics prior to the consult, including a review of the Provider's credentials.
- I understand that federal and state law requires health care providers to protect the privacy and the security of health information. I understand that LoginClinics will take steps to make sure that my health information is not seen by anyone who should not see it. I understand that telehealth may involve electronic communication of my personal medical information to other health practitioners who may be located in other areas, including out of state.
- I understand there is a risk of technical failures during the telehealth encounter beyond the control of LoginClinics. I agree to hold harmless LoginClinics for delays in evaluation or for information lost due to such technical failures.
- 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. I understand that I may suspend or terminate use of the telehealth services at any time for any reason or for no reason. I understand that if I am experiencing a medical emergency, that I will be directed to dial 9-1-1 immediately and that the Providers are not able to connect me directly to any local emergency services.
- I understand that alternatives to telehealth consultation, such as in-person services are available to me, and in choosing to participate in a telehealth consultation, I understand that some parts of the services involving tests may be conducted by individuals at my location, or at a testing facility, at the direction of the Provider (e.g. labs or bloodwork).
- 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 understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Persons may be present during the consultation other than the Provider in order to operate the telehealth technologies. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telehealth examination; and/or (3) terminate the consultation at any time.
- I understand that I will not be prescribed any narcotics for pain, nor is there any guarantee that I will be given a prescription at all.
- I understand that if I participate in a consultation, that I have the right to request a copy of my medical records which will be provided to me at reasonable cost of preparation, shipping and delivery.

- I have had a conversation with my Provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

Patient Consent

I have read this document carefully, and understand the risks and benefits of the telehealth consultation and have had my questions regarding the procedure explained and I hereby give my informed consent to participate in a telehealth consultation under the terms described herein.

By signing this "INFORMED CONSENT FOR TELEHEALTH SERVICES" I hereby certify,

- That I have read or had this form read and/or had this form explained to me.'
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Signature of Patient or Legal Guardian

Patient Name: _____

Date: _____