Crescent
NEUROLOGY AND SLEEP

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Instructions and Consent for Telehealth (Virtual) Visits

Instructions:

1. You must use a computer, tablet, or cell phone with a camera installed. *Please note:* If you are connecting with 2 parties at separate locations, use a laptop or tablet. Connections via cell phones in this situation do not work well.
2. Please be sure to check that your device's video and audio connections are functioning.
3. Connection with a strong WIFI is highly recommend for a better connection.
4. Please sit in a bright and quiet area where you can discuss your private health information to maintain HIPPA compliance on your end.
5. You will receive an email from *ExamMed* (telehealth platform) when your appointment is scheduled -you may have to "accept" the clinic as one of your providers. (There is no need to set up an account with ExamMed because you will be sent a different link to your email address at your appointment time)
6. Please be waiting for an email at your appointment time for a link to click on. This link is sent by Dr. Quraishi when she is ready to start the visit. Please note you may need to wait a few minutes past your appointment time as may if you were in the office. If she is running more than 5 minutes late, you will get a call from our office to notify you.
7. There may be a pop-up that shows on your screen. Please allow access. If the pop-up disappears before you allow access, then refresh the screen to bring back the pop-up.

Please note: If there are any technical issues, this will not count towards your visit time. If the technical errors cannot be fixed immediately, your appointment can be rescheduled.

Consent:

1. Medical Information and Records: All existing laws regarding your access to medical information and copies of your medical records apply. The date, time, and length of your visit will be recorded, but not all video/sound is recorded. Dissemination of any patient identifiable images or information for this telehealth interaction to researchers or other entities shall not occur without your consent.
2. Confidentiality: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telehealth visit, and all existing confidentiality protections under federal and state law apply to information disclosed during this visit.
3. Rights: You may withhold or withdraw consent to the telehealth visit at any time without affecting your right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.
4. Financial Responsibility: You are held to the same co-pay and co-insurance responsibilities as stated in the "Financial Policies and Disclosure" (can be found on our website). In order to continue with telehealth visits, you will need to pay any outstanding balances.
5. Disputes: You agree that any dispute arriving from the telehealth visit will be resolved in the state the practice resides, and that state law shall apply to all disputes.
6. Risks, Consequences & Benefits**:** You understand that telehealth has its benefits and limitations compared to an in-office visit and agree to be seen under these limitations. You have had the opportunity to ask questions about the information presented on this form and all your questions have been answered.

By signing below, you agree to participate in telehealth visits.

Patient's printed name : ______________________________

Patient's signature (or guardian if patient is a minor: ______________________________

Relationship to patient and Date: ______________________________