TELEHEALTH CONSENT FORM

I, the undersigned Patient, consent to have telehealth visits with Elie Sader, MD, PLLC ("the Practice"). This means that I will, through interactive video connection, be able to consult with the Practice about my health.

By signing this form below, I agree to and understand the following:

I represent that I am located in the State of New York, Connecticut or California and will continue to be while receiving telehealth services from the Practice.

I further represent that I will be in a private, secluded space while receiving telehealth services from the Practice.

I understand that telehealth visit is not the same as a direct patient/provider visit due to the fact that I will not be present, in person, at the Practice.

I understand that the Practice will provide information to assist in my understanding of certain medical conditions and will provide general counsel on health issues.

I understand that there are potential risks by using this technology, including but not limited to the following: (1) the video connection may not work or that it may stop working during the consultation; (2) the video picture or information transmitted may not be clear enough to be useful for the consultation; and (3) there may be access by unauthorized persons due to the technology and breach of said technology by no fault of the Practice or me.

I understand that the benefits of telehealth visits, including but not limited to, are the following: (1) I do not need to travel to the consultation location and (2) I have access to a specialist through this method.

I understand that the Practice or I may discontinue telehealth services if it is felt that the connections are not adequate for the situation or if either of us feel that the consultation has been compromised in any way.

I understand that my healthcare information may be shared with other individuals for scheduling purposes. I further understand that other individuals may also be present during the consultation in order to operate the video equipment. The above-mentioned people will take reasonable steps to maintain confidentiality of the information obtained. I also understand that I will be informed of their presence prior to the start of the consultation and will have the right to request the following: (1) omit specific details of my health history that are personally sensitive; (2) ask non-medical personnel to leave the teleconsultation room: and or (3) terminate the consultation at any time.

I understand that it is solely my responsibility to contact my local hospital/emergency room for any healthcare emergency or urgent matter.

While there have been no warranties, assurances, or guarantees made to me, I consent and freely agree to obtain telehealth services from Elie Sader, MD, PLLC. I have read and understood the information provided in the Consent form, as well as all materials provided to me.

I further agree to hold Elie Sader, MD, the Practice and any associates or staff of the Practice harmless from any and all liabilities and claims that may arise as a result of participation in telehealth services and the authorized use of such videotapes, digital recording films and photographs. I will not hold them responsible for the consequences of any decisions I may make, or any actions I may take, or may choose not to take, following the consultation.

I represent that I am of sound mind and am legally competent to understand and complete this agreement. I hereby execute this consent form without coercion.

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Patient's Signature Date

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Patient's Printed Name