Dr. Denise Persichino, D.O.
Board Certified in Psychiatry

CONSENT TO USE TELEMEDICINE

Patient's Name:____ Provider's Name:_Dr. Denise Persichino, D.O._

I am physically located in in Rancho Cucamonga, California. At the beginning of each telemedicine session, I will help my doctor to complete a check-in to assess the suitability of using telemedicine services by verifying my full name, current location, readiness to proceed, and whether I am in a location conducive to a private, uninterrupted communication. By signing this consent, I understand and agree :

1.My provider is located and licensed by the State of California. My provider may not be able to prescribe medications for me and/or may not be able to assist me in an emergency situation when I am located in another state or country. If I require emergency care, I will call 911 or proceed to the nearest emergency hospital or emergency room for help.

2. I submit to the exclusive jurisdiction of of the California State superior courts and agree that any claim, lawsuit, or other legal proceeding arising out of our relating to the telemedicine services provided by my provider and my providers staff will be brought solely and exclusively in California State superior courts. I also agree that the interpretation of this consent will be exclusively governed by and constructed in accordance with the laws of California.

3. My provider believes telemedicine services are appropriate for my mental health condition and that I would benefit from its use despite its risks and limitations. While I may expect anticipated benefits from the use of telemedicine, no specific results can be guaranteed or assured.

4. If my provider believes at any time that another form of service (for example, a traditional in person consultation or appointment) is appropriate, my provider may discontinue telemedicine services and schedule an in person appointment or refer me to a healthcare provider in my area who can provide such services.

5. I have the right to withdraw consent to the use of telemedicine services at any time and receive in person healthcare services with my provider.

6. I received an explanation of how the electronic communication technology will be used for telemedicine services. I am comfortable with using electronic communications technology to communicate with my doctor and understand there are limitations to the technology which may require an in person consultation.

7. I agree to have the necessary computer, equipment, and internet access for my telemedicine communications. I also agreed to arrange for a location with sufficient lighting and privacy free from distractions and intrusions during my telemedicine communications.

8. The laws that protect privacy and the confidentiality of my medical information also apply to telemedicine. The medical information. The medical information that is transmitted electronically by my provider to me will be encrypted during transmission and will be stored only by my doctor on a service provider selected by my doctor. I understand the dissemination of any personally to researchers or other healthcare providers will not occur except as required by Federal or California state law.

9. I understand my risks of a privacy violation increase substantially when I enter information on a public access computer, use a computer that is on a shared network, allow a computer to "auto remember" usernames and passwords, or use my work computer for personal communications. I also understand that it is my responsibility to encrypt medical information I transmit

electronically to my provider and my failure to use technical safeguards, such as encryption increase my risk of a privacy violation.

10. I understand that no part of the encounter will be recorded without my written consent.

11. I understand that the telemedicine services provided to me will be charged to my credit card on file.

12. I understand that if I do not provide notification of the canceled appointment within our no show policy timeframe, per office protocol I will be charged the full amount of the missed appointment.

13. I agree to follow the protocol outlined above for all telemedicine appointments unless otherwise directed by my provider.

Name of patient: ____

Signature/Date: ____