LEHIGH VALLEY DERMATOLOGY ASSOCIATES, LTD.

DAVID B. VASILY, M.D.
MICHELLE D. RAMSBERGER, PA -C
SARAH J. HARTMAN, PA-C
LIANNE MCGINN-BUNN, PA-C
JENNA WEIDNER, PA-C

940 NORTH NEW STREET
BETHLEHEM, PA 18018
(610) 866-2010
FAX (610) 866-4359

Dear New Patient,

Welcome to our practice. Although the following forms may seem complicated, they can help us better understand your skin condition and possible relationship to your general medical health.

Simply do the best you can with these forms. Our assistants can help you with specific questions when you are in the exam room.

Your appointment is very important to you and to us. During each day, we have a limited number of appointments available to accommodate all our patients. If you are not able to keep your appointment, we require notice at least 24 hours before your scheduled appointment so that we can attempt to fill the spot with another patient. **If notice of cancellation is not given at least 24 hours in advance of your appointment, you will be charged a fee of $155.00.** That fee will be charged to your credit card that is on file with the office. Payment of this fee is required before you can reschedule your appointment. By signing below, you acknowledge notice of our cancellation policy and agree to abide by its terms.

Sincerely,

David B. Vasily, M.D.
Michelle Ramsberger, PA-C
Sarah Hartman, PA-C
Lianne McGinn-Bunn, PA-C
Jenna Weidner, PA-C

LEHIGH VALLEY DERMATOLOGY ASSOCIATES, LTD

Medical Record # _____

Account # _____

DERMATOLOGIC MEDICAL HISTORY

Patient: _____ Age: _____ DOB: _____ Date: _____

Family Doctor: _____ Referring Physician (if any) _____

Leave message on answering machine: _____ yes _____ no

Chief Complaint (reason for today's visit). If you can, provide additional information about today's complaint including duration prior to treatment and itching. _____

_____

_____

Allergies: ____ hayfever ____ latex ____band-aids ____ Betadine ____ Neosporin ____ lidocaine

List all medication allergies (lidocaine, sulfa, penicillin) _____

_____

_____

Surgical History - especially heart valve, pacemaker, and joint replacement surgery. _____

_____

List all medications you are currently taking:

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

Do you take aspirin? Yes ____ No ____

Do you take prophylactic antibiotics for dental work: Yes ____ No ____ If yes, why? _____

_____

Medical History (include diabetes, high blood pressure, skin cancer, internal cancer):

_____

_____

Family History _____ psoriasis _____ eczema _____ skin cancer _____ melanoma

_____

Social History: Occupation _____

Do you smoke cigarettes?: ___ Yes ___ No Duration _____ Do you consume alcohol? ___ Yes ___ No

Preferred Pharmacy:

Local Pharmacy: _____

Mail Order: _____

Completed by: ____ Patient
____ Medical Assistant _____
Initials

Reviewed by Physician/Physician Assistant _____
Date

_____
Signed by Patient Date

_____
Reviewed by Date

DO YOU HAVE ANY OF THE FOLLOWING:

GENERAL	YES	NO
Tire easily, weakness		
Recent weight loss		
Loss of appetite		
Fever/chills		
SKIN		
Any skin lesions removed		
Itching or dryness		
Hair or nail changes		
HEENT		
Visual changes		
Glaucoma		
Loss of hearing		
Ringing in ears		
Sinus problems		
Sore throat/hoarseness		
NERVOUS SYSTEM		
Convulsions/epilepsy		
Dizziness/fainting		
Psychiatric treatment		
RESPIRATORY		
History of tuberculosis		
History of emphysema		
History of asthma/hay fever		
Persistent cough/cold		
ENDOCRINE/IMMUNOLOGY		
Diabetes		
Thyroid condition/goiter		
Arthritis/rheumatism		
Other		
URINARY		
Kidney disease		
Increase in frequency in urination (night)		
Burning on urination		
Urethral discharge		
Bloody urine		

HEART/BLOOD VESSELS	YES	NO
Valve replacement		
Pacemaker		
Defibrillator		
History of rheumatic fever		
Heart murmur		
Chest pain/discomfort		
Heart attack/trouble		
Shortness of breath		
Swelling of ankles		
High blood pressure		
Other heart problems		
DIGESTIVE SYSTEM		
History of hepatitis		
History of jaundice		
History of ulcers		
Black, blood or pale stools		
BLOOD		
Bruise easily		
Anemia		
Frequent nose bleeds		
REPRODUCTIVE		
Irregular menses		
Currently pregnant?		
Breastfeeding		
Post-menopausal		
Nipple discharge		
OTHER		
Radiation therapy		
Chemotherapy		

I have either read or been asked and replied to the questions above and have completed them to the beast of my knowledge. I have not omitted any other medical information from my history. I am aware that Lehigh Valley Dermatology Associates Limited are not responsible for medical evaluation of any complaints not related to my skin that have not been attended to by my personal medical physician or primary care physician. I agree to see my primary care physician for any medical conditions I am currently aware of or are detected during medical evaluation that are unrelated to my dermatology condition.

Finally, I understand that doctors encourage a complete skin exam and that refusal to have this exam done could have deleterious effects on my health, including failure to detect skin cancer, melanoma, etc. I also understand that the skin is the largest organ of the body and that, it is impossible for the doctors to be responsible for examining every inch of skin covering my body.

Vaccination Status

For patients 65 and older: Have you received a pneumonia vaccination? Yes ☐ No ☐

Have you received an influenza vaccination? Yes ☐ No ☐

Advanced Care

Do you have a health care proxy in the event you are unable to make your own medical decisions? Yes ☐ No ☐

Do you have a living will? Yes ☐ No ☐

Do you have a health care proxy in the event you are unable to make your own medical decisions? Yes ☐ No ☐

Designee's Name : _____

Designee's Phone Number: _____

Which statement(s) best reflects your wishes on advanced care recommendations?

☐ Do Not Intubate: I do not wish to have a breathing tube, even if it is necessary to save my life.

☐ Do Not Resuscitate: If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if its necessary to save my life.

☐ Full Cardiopulmonary Resuscitation: I want full cardiopulmonary resuscitation efforts to be made.

Family History of Melanoma? Yes ☐ No ☐ Relationship: _____

Skin Protection

Do you wear sunscreen? Yes ☐ No ☐

If yes, what SPF _____

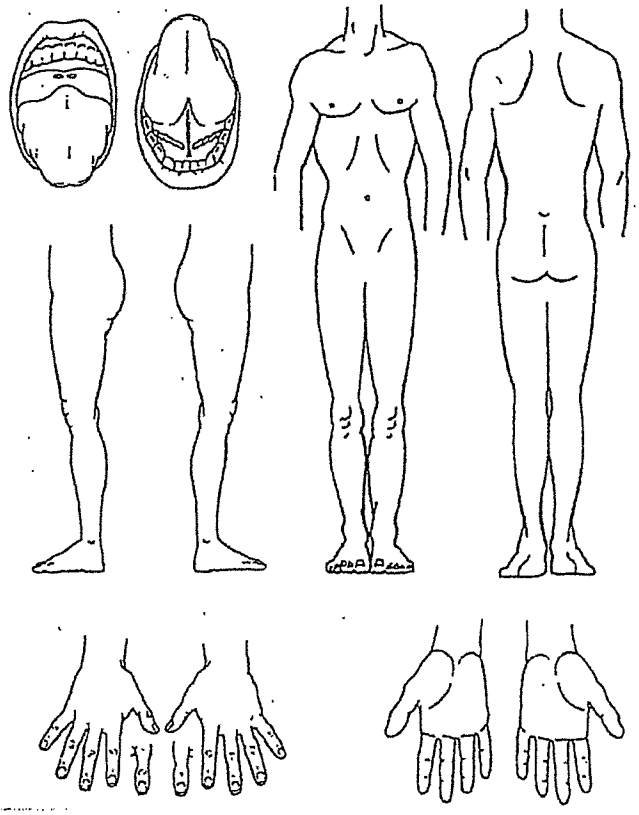
Do you tan in a tanning salon? Yes ☐ No ☐

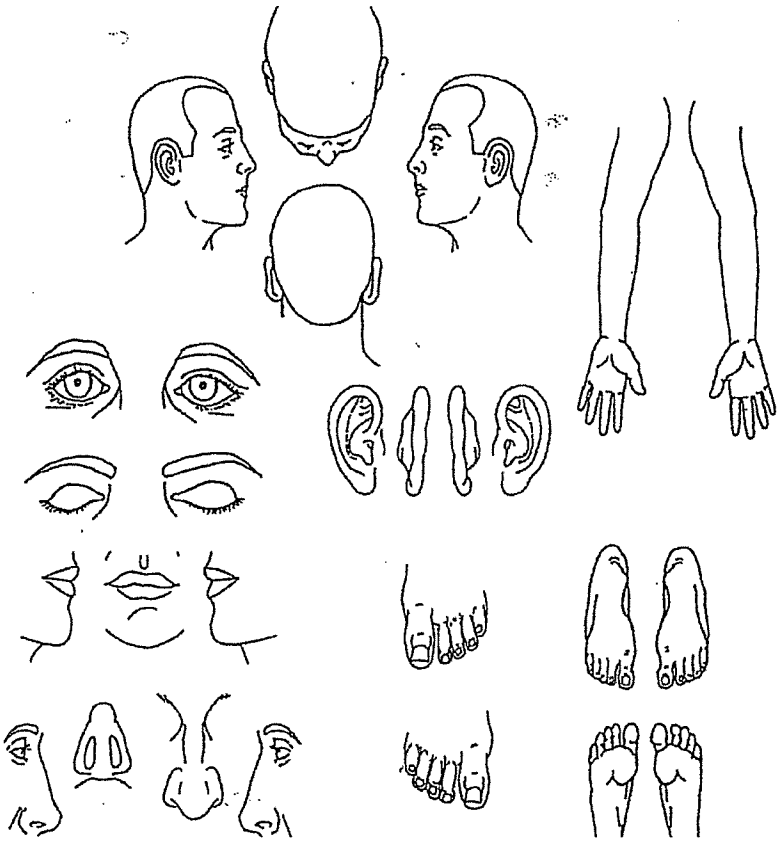
LEHIGH VALLEY DERMATOLOGY ASSOCIATES, LTD.

Name: _____

Vital signs: General Appearance: _____

BP: _____ Pulse: _____ RR: _____





MEDICATION LIST

Name:_____ DOB: _____

ALLERGIES or reactions to medications: ____ Yes ____ No; If yes, list medications: _____

_____

_____

PACEMAKER: ____ Yes ____ No

ARTIFICIAL JOINT: ____ Yes ____ No

HEART VALVE DISEASE OR REPLACEMENT: ____ Yes ____ No

LIST CURRENT MEDICATIONS BELOW. (If no medications, write "**none**," or if attached sheet, write "**see attached**.")

PRESCRIPTION MEDICATIONS
OVER-THE-COUNTER MEDICATIONS (including aspirin, vitamins, herbals)

LOCAL PHARMACY: _____

MAIL ORDER PHARMACY: _____

May message be left on your personal answering machine: ____ Yes ____ No

Medical Assistant: Please check and date.

NO SHOW ATTESTATION POLICY

Due to an increasingly prevalent problem of no show follow up and new patient visits to our office, we are forced to implement our new no show policy as outlined below. The effect of these no show visits is that the medical costs, to our other compliant patients, are driven up and *valuable time slots are taken away from patients who need appointments.*

	DESCRIPTION	FEE	CONSEQUENCES
1.	No show number one	$25.00	Fee only
2.	No show number two (consecutive)	$25.00 first no show $50.00 second no show	Fee only
3.	No show number three (scattered or consecutive)	$25.00 first no show $50.00 second no show $75.00 third no show	Discharge from practice

I have read the above and completely understand the language and meaning of the attestation no show policy given to me, and I have had a chance to ask questions of my doctor or staff about this policy and am willing to comply with Lehigh Valley Dermatology's no show policy. I understand the terms above and realize that if I violate the Lehigh Valley Dermatology's no show policy, I will be discharged from the practice and pay for no show visits, and that any and all means necessary to collect the fees for the no show visits will be pursued.

I have read the above no show attestation policy and agree to the terms of the policy.

_____ _____

Patient Name - please print Date of birth

_____ _____

Patient signature Date

_____ _____

Witness Date

MEDICARE

I request that payment authorized Medicare benefits be made on my behalf to Lehigh Valley Dermatology Associates, Ltd. for any services furnished me by that physician group. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services.

Signed (insured or authorized person) _____
A copy of this signature is valid as the original.

MEDIGAP

Name of Medigap Insurer: _____ Medigap Policy#: _____

Medigap Insurer's Mailing Address: _____

_____

I request that payment of authorized Medigap benefits be made either to me or on my behalf to Lehigh Valley Dermatology Associated, Ltd. for any services furnished me by the physician group. I authorize any holder of medical information about me to release to _____ and its agents any information needed to determine these benefits or the benefits payable to related services.

Signed (insured or authorized person) _____
A copy of this signature is valid as the original.

INSURANCE AUTHORIZATION

I hereby authorize release of any information necessary to file a claim with my insurance company and assign benefits otherwise payable to me to Lehigh Valley Dermatology Associates, Ltd. I understand that I am financially responsible for any balance not covered by my insurance carrier.

Signed (insured or authorized person) _____
A copy of this signature is valid as the original.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: _____ Date of Birth: _____

Address: _____

Practice Name: Lehigh Valley Dermatology Associates, Ltd.

I have been given a copy of Lehigh Valley Dermatology's Notice of Privacy Practices ("Notice"), which describes how my health information is used and shared. I understand that Lehigh Valley Dermatology has the right to change this notice at any time. I may obtain a current copy by contacting the Regulatory Compliance Manager's email (audrey@lehighvalleyderm.com), or by visiting the Lehigh Valley Dermatology's web site at **lehighvalleyderm.com.**

My signature below acknowledges that I have been provided with a copy of the *Notice of Privacy Practice:*

_____ _____
Signature of Patient or Personal Representative Date

_____
Print Name

_____
Personal Representative's Title (e.g., Guardian, Executor of Estate, Health Care Power of Attorney)

For Facility Use Only: Complete this section if you are unable to obtain a signature.

1. If the patient or personal representative is unable or unwilling to sign this *Acknowledgement,* or the *Acknowledgement* is not signed for any other reason, state the reason:

_____

_____

2. Describe the steps taken to obtain the patient's (or personal representative's) signature on the Acknowledgement:

_____

_____

Completed by:

_____ _____
Signature of Practice Representative Date

HIPAA PATIENT COMMUNICATION FORM

A. Family and Friends: It is the office policy of Lehigh Valley Dermatology Associates not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that that person is entitled to receive information regarding your treatment, (iv) in emergency situations or (v) other, as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers/babysitters, please indicate that below. If you do not want any of your medical information provided to a family member, please check (✓) the line next to the "no" response. By signing below, you authorize the following people to receive information regarding your treatment or care. If you wish to add names later on, please confirm this in writing or call our staff.

Spouse: _____ _____ No

Parent: _____ _____ No

Other: _____ _____ No

_____ _____ No

_____ _____ No

B. Alternative Communications: You are also entitled to specify alternative, reasonable means of communication, if you do not wish to be contacted by us in a certain way.

I hereby request the following means of contact only: _____

_____

_____

PRINTED NAME: _____

Patient/Parent/Guardian Signature: _____

Date: _____

FOR OFFICE USE

Changes to above authorized by patient over the phone:

Change	Date	Staff Initials
_____	_____	_____
_____	_____	_____
_____	_____	_____

Lehigh Valley Dermatology Associates, Ltd.
940 N New St
Bethlehem, PA 18018
610-866-2010

Patient Consent for Medical Photography

Patient Name:_____ DOB:_____ Date:_____

- o Check here if you are a minor or unable to provide consent.

I consent for medical photographs to be made of me or my child (or person for whom I am legal guardian). I understand that the information will be used in my medical record, for purposes diagnosis, tracking my progress, progression of a condition and or treatment, keeping a visual history, medical teaching and reporting to referring physician. Refusal to consent to photographs will in no way affect the medical care I will receive. However, please keep in mind refusal may limit our ability to track your progress or progression of a condition if we do not have visual documentation. I understand that I am able to withdraw my consent at any time.

- o To withdraw my consent in the future I may contact:
  Office Manager - Kristin Hardiman – (610) 866-2010
- o Questions pertaining to patient rights will be filtered through the Office Manager to the Regulatory Compliance Manager – Audrey Kovacs

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By signing this form below I confirm that this consent has been explained to me in terms in which I understand.

1) I consent for my photographs to be used in medical record as part of my visual patient history for purposes of diagnosis, tracking my progress or progression of a condition and/or treatment and to provide a copy to my medical image(s) to include at the referring physician's office.

_____ (Print) _____ (Signature)

2) I agree for my medical image(s) to be used for medical teaching purposes.

_____ (Print) _____ (Signature)

3) I DO NOT consent to any medical images to be taken. I understand that refusal to consent to medical images taken as part of my medical record may limit my provider's ability to effectively track my progress or progression of a medical condition.

_____ (Print) _____ (Signature)

Office Employee Witness _____

Lehigh Valley Dermatology Associates
940 N New Street
Bethlehem, PA 18018

Financial Policy Update

Credit Card on File Policy and Authorization

Dear Patients,

This letter is to inform you of our updated billing practice in regards to receiving patient payments. Effective November 11, 2018, we now require a credit or debit card to be on file with our office or full patient payment of services at each appointment.

Why the change?

There are several reasons for this change. With the changing environment in healthcare, more responsibility of payment is being placed on the patient. We are not equipped to provide inhouse financing and need to be sure that patient balances are paid at the time of service or in a timely manner. To do this, we need to ensure we have a guarantee of payment on file in our office.

What is a Deductible and How Does It Affect Me?

An annual deductible is the dollar amount you must pay out of pocket during the year for medical expenses before your insurance coverage begins to pay. For example, if your policy has a $2,000 deductible, you must pay the first $2,000 of medical expenses before the insurance company begins to pay for any services. This works just like the deductible for your car insurance or homeowner's insurance policy does.

When does a deductible begin?

Your deductible begins at the start of your plan year. Most plan years begin either January 1 or July 1, but plans can start on any date.

When do I have to pay for services?

Any time you receive medical care, you will be expected to pay in full for your services until your deductible is met. If you have a very large deductible, called a high-deductible insurance plan, you may have to pay out of pocket for most of your primary care services.

How will I know when my deductible has been met?

You can call your insurance company at any time to check on how much of your deductible has been met and some insurance companies have this information available online. Every time you receive medical services, you will receive notification from your insurance company with how much they paid or did not pay if the amount went to your deductible when they send you an Explanation of Benefits (EOB.) Your agreement with your insurance company is between you and your insurance company. We submit on your behalf but do not have control over what they pay or do not pay.

Lehigh Valley Dermatology Associates
940 N New Street
Bethlehem, PA 18018

But I always pay my bills, why me?

We have to be fair and apply the policy to all patients. We have wonderful patients and we know that most of you pay your balances. Unfortunately, this is not always the case.

How will I know how much you are going to charge me?

You will receive a letter in the mail from your Insurance carrier that explains how much of your office visit they pay and how much you pay. This is called an Explanation of Benefits (EOB.) This letter tells you exactly, according to your health insurance coverage, how much of your health care bill is your responsibility and how much is the responsibility of your insurance to pay.

Then what?

We receive the same Explanation of Benefits (EOB) that you do. Most Insurance will send your EOB prior to us receiving our copy. It arrives about 10-20 days after your appointment has been billed. We look at each EOB carefully and determine what your insurance has determined as patient responsibility. This is the same way we normally determine how much to send you a statement for in the mail.

Will you send me a bill to let me know what I owe?

All patients with commercial insurance are required to keep a credit or debit card on file. If you do not wish to keep a card on file, we will expect an estimated payment at the time of service. For example, if your commercial insurance requires $95.00 to be paid for standard service and your deductible is not met, you will be expected to pay the $95.00 via check or cash before you are seen, but this will not include ancillary charges that may arise out of your visit. Once we receive the EOB on your visit we will send a statement if your patient responsibility is higher than the originally collected amount or you will have a credit on your account if your patient responsibility is lower than the originally collected amount. The best way to avoid this confusion is to keep your credit card on file. Once we receive the insurance EOB for your visit we will charge the credit card on file the exact amount as per the EOB that is stated to be patient responsibility. Once charged, we will email you a receipt of payment.

When do I give you my credit card?

We prefer for you to fill out the Credit Card Authorization Form and give us your credit card in person. You can provide your credit card information over the phone, by mail, or in person. My High-Deductible Health Plan has a Health Savings Account (HSA) Card.

Lehigh Valley Dermatology Associates
940 N New Street
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Can I keep my HSA card on file?

Yes, you can keep your HSA card on file, however, we may require an additional card to be kept on file should the funds in your HSA account become insufficient.

Can I keep my Care Credit Card on file?

Yes, you can keep your Care Credit card on file. We will require any high cost procedure out of pocket expense to be charged to Care Credit charge card on the first visit to prevent a large account balance from accruing.

What if I need to dispute my bill?

We will always work with you to understand if there has been a mistake. We will refund your credit card if we or if your insurance company has made a billing error. We will only charge the amount that we are instructed to by your insurance carrier, in the EOB they send to us, in the same way that we normally determine how much to send you a bill for in the mail.

What if I have more questions?

Our staff is happy to speak with you about your account at any time at 845-369-3550. Your information will NOT be shared with any third parties.

Credit Card on File Policy

As you may be aware, the current healthcare market has resulted in insurance policies increasingly transferring costs to you, the insured. Some insurance plans require deductibles and copayments in amounts not known to you or us at the time of your visit. As a result, we require that all patients need to have a credit or debit card number on file with our office. Similar to hotels and car rental agencies, you are asked for a credit card number at the time you check in and the information will be held securely until your insurance company has paid their portion and notified us of the amount of your share. If there is a balance, your credit card will be automatically charged following receipt of your insurance's Explanation of Benefits showing processing of your claim for any portion you are legally responsible to pay. If following receipt of the claim's Explanation of Benefits we receive any unexpected information regarding your payment responsibility, we will promptly notify you to give you an opportunity to address with your insurance company before we charge your credit card. This also allows you to check out easier, faster, and more efficiently as you can simply ask our staff to charge the copay to your 'card on file'. Please be assured that this payment method in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment. You are responsible for updating any credit card information changes with Lehigh Valley Dermatology Associates in the event of a change. If you have any questions about this payment method, do not hesitate to ask.

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If you do not wish for us to keep your credit card on file, you agree to pay any co-pays, co-insurances and deductibles at the time of service. However, the authorization must be signed in order for us to process any credit card(s). In the event you decide not to sign the credit card authorization, we would require your balance to be paid at the time of service by cash or check only.

If you do not have insurance, you will be expected to pay for your balance in full at the time of service. If you require multiple treatments, the entire balance will be paid in full on the first treatment day in order to avoid large account balances.

If you require multiple treatments and your insurance does not cover the treatment in full or at all. The balance or estimated balance will be paid on the first treatment date.

PATIENT EASY PAY CONSENT

I authorize Lehigh Valley Dermatology Associates to charge my credit card for any patient responsibility amount after claims are submitted and processed by my insurance or for my account balance (the card may be on file, called in over the phone or presented in person.)

These balances may include: Patient copay(s), Deductible/HSA deductible, Care Credit for any unpaid balance.

By signing below, you acknowledge and agree with the following:

I have received and read the Lehigh Valley Dermatology Associates' Deductible, Copay, Out of Pocket Financial Policy and agree to the terms. I agree to provide a valid credit/debit card and allow Lehigh Valley Dermatology Associates to charge my HSA debit/credit card or the personal credit card provided upon receipt of my insurance EOB. I understand Lehigh Valley Dermatology Associates will not alter my treatment plan due to possible charges incurred. This agreement will be kept on file for any future payments to my account balance whether the card is kept on file or presented to LVD through phone or in person.

X _____ X _____

Cardholder's Signature Date

Lehigh Valley Dermatology Associates
940 N New Street
Bethlehem, PA 18018

Patient Name(s) _____ Cardholder Name _____

Cardholder Address _____

City_____ State_____ Zip Code _____

Credit/Debit Card Number_____ CVV_____ Exp. Date_____

Please circle one: VISA MASTERCARD DISCOVER AMERICAN EXPRESS

***This form will be shredded upon entry into our billing system

Your information will NOT be shared with any third parties

***PLEASE NOTE THAT THE CHARGE WILL APPEAR AS (Enter how charge will appear) ON YOUR CREDIT CARD STATEMENT

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BETHLEHEM, PA 18018
(610) 866-2010
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INFORMED CONSENT FOR TELEMEDICINE SERVICES

Patient Name: _____

Date of Birth: _____ Medical Record:_____

Patient Address: _____ City, State:_____ Zip: _____

Date Consent Discussed:_____ Physician Name: _____ Location: _____

INTRODUCTION Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

Electronic systems used 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.

EXPECTED BENEFITS

- Improved access to medical care by enabling a patient to remain in his/her office (or at a remote site) while the physician obtains test results and consults from healthcare practitioners at distant/other sites.
- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist.

Please initial after reading this page:_____

INFORMED CONSENT FOR TELEMEDICINE PAGE 2

POSSIBLE RISKS As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reaction or other judgment error;

BY SIGNING THIS FORM, I ATTEST TO AND UNDERSTAND THE FOLLOWING:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent, 2. 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, 3. I understand that I have the right to inspect all information obtained and recorded in the course of telemedicine interaction, and may receive copies of this information for a reasonable fee, 4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. _____ has explained the alternatives to my satisfaction, 5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state. 6. I understand that it is my duty to inform _____ of electronic interactions regarding my care that I may have with other healthcare providers. 7. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured. 8. I attest that I am located in the state of Pennsylvania and will be present in the state of Pennsylvania during all telehealth encounters with _____.

PATIENT CONSENT TO THE USE OF TELEMEDICINE I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby authorize (_____) to use telemedicine in the course of my diagnosis and treatment.

PATIENT'S SIGNATURE: _____ **DATE:**_____
(OR AUTHORIZED PERSON TO SIGN FOR PATIENT)

_____ **WITNESS DATE:** _____
IF AUTHORIZED SIGNER, RELATIONSHIP TO PATIENT

_____ **DATE:** _____
PHYSICIAN'S SIGNATURE

I have been offered a copy of this consent form. _____