WEBCAM TELEHEALTH INFORMED CONSENT

I give my consent to engage in telemedicine with Dr. Scott Phillips and understand that "telemedicine" includes assessment, examination, review of medical records/images, and diagnosis.

I understand that the same principles of patient privacy (aka HIPAA) apply and that I have already received, accepted, and have access to those notices and that that there are unique technological risks related to telemedicine such as the possibility for problems that could result in either the loss of a connection and/or unintended interception of the electronic information by non- approved persons or entities (aka cyber hack), etc.

By agreeing to participate in telemedicine, I affirm that I do not have any Red Flags that would require immediate evaluation such as calling 911 or going to an Emergency Room. Red Flags for neurosurgery include, but at not limited to new onset symptoms such as: weakness, paralysis, stroke-like symptoms, loss of sensation to part of the body, altered awareness or consciousness, altered speech, loss of bowel/bladder function (incontinence), inability to walk, and /or loss of function in the hands, arms, legs, feet, and other similar symptoms.

I understand that telemedicine may not be as complete as an in-person clinic evaluation, but that a Good Faith effort will be made to conduct the most thorough exam possible via webcam. Factors such as lighting, positioning in the camera's view, image quality, etc. could also make the exam less reliable. I also understand that diagnoses may be missed that may have otherwise been found and I accept this risk. I understand that I still have the option for a traditional face-to-face office visit.

I understand the exam-over-webcam is not the only factor in the assessment. My provider will also use information from the interview (my reporting of my problems, symptoms, etc.) and correlation with my images if they were performed and are available. With these combined data, I understand and accept that my provider will make a Good Faith effort to provide the best care possible via telehealth.

I understand that my provider may determine that I have a medical problem requires immediate face-to-face medical setting (eg. Emergency room) and it will be my responsibility to follow any advice for further face-to-face care.

Finally, I promise that any information provided will be true and accurate to the best of my ability and omitting medical information may result in an inaccurate diagnosis and treatment.

SIGNATURE PRINTED NAME DATE