Shanti Wellness, LLC
28 Millburn Avenue, Suite 7
Springfield, NJ 07081
908-447-8593
www.shantiwellnessllc.com

Consent for Telemedicine

Patient Name: _____ Date of Birth: _____

1. I understand that my health care provider would like to engage in a telemedicine consultation/evaluation.

2. My health care provider has explained to me how the video conferencing technology will be used to provide this consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.

3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I also understand that this type of appointment will be different than an in-person appointment in that there may be information that my doctor may not be able to gather through this audio-visual technology. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections or privacy are not adequate for the situation.

4. I understand that the benefits of using telemedicine is easier access to services and less risk of exposure to contagious illnesses.

5. If I am a minor, I understand that other people, such as parents/guardians, may also be present during the consultation. My confidentiality will be maintained in accordance with the practice policy and privacy laws. I also understand that if there are any safety issues or other issues that put my health/safety at risk, then my parent(s)/guardian may be notified during the session. I further understand that I will have the right to request the following:

(1) omit specifics of my medical history/evaluation that are personally sensitive to me, unless my parent/guardian needs to know about them for safety reasons;
(2) ask non medical personnel to leave the telemedicine exam room (if applicable);
(3) end the consultation at any time.

6. I have had the alternatives to a telemedicine consultation explained to me, including in-person sessions, and I am choosing to participate in a telemedicine consultation.

7. I understand that some parts of the evaluation involving physical tests or labs will be conducted at a different facility of my choice. I also understand that I may be asked to purchase a blood pressure kit and weighing scale to check my child's vital signs at home.

8. I understand that there is no difference in the charges for telemedicine sessions vs. in-person sessions.

9. I have had the opportunity to ask questions in regard to telemedicine. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

By signing this form, I certify:

 That I have read or had this form read and/or had this form explained to me

 That I fully understand its contents including the risks and benefits of the procedure (telemedicine).

 That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Name of patient (print):_____
Signature of patient: _____ Date: _____

Name of parent/guardian (print):_____
Signature of parent/guardian: _____ Date: _____

Name of clinician (print): Sonali Mahajan, MD

Signature of clinician: _____Date: _____