By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine/telehealth services, and that no information obtained in the use of telemedicine/telehealth services which identifies me will disclosed to other entities without my consent.
2. I understand that I have the rights to withhold or withdraw my consent to the use of telemedicine/telehealth 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 a telemedicine/telehealth interaction, and may receive copies of this information for a reasonable fee.
4. I understand that a variety of alternative methods of medical/health care may be available to me, and that I may choose one or more of these at any time. My doctor/therapist has explained the alternatives to my satisfaction.
5. I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.
6. I understand that insurance coverage of telehealth sessions may differ based on my insurance plan. It is in my best interest to check with my insurance company regarding the coverage.
7. I understand that I am fully responsible for co-payments and deductible amounts, and that I am fully responsible to pay the provider if telehealth/telemedicine sessions are not covered by my insurance company.

Patient Consent to the Use of Telehealth/Telemedicine Services

I have read and understand the information provided above regarding telehealth/telemedicine services, have discussed it with my physician/therapist, and all of my questions have been answered to my satisfaction. I hereby give consent for the use of telehealth/telemedicine services in my care.

I hereby authorize MUHAMMAD NADEEM SHAMSI P.C to use telehealth/telemedicine services in the course of my diagnosis and treatment.

Signature of patient (or person authorized to sign for the patient):

________________________________ *Date:* ____________

If authorized signer, relationship to patient: ______________________

Witness ______________________ *Date* ____________

I have been offered a copy of this consent form (patient's initials): _______