THE CLINICAL SKIN CENTER OF NORTHERN VIRGINIA , PLLC

3700 JOSEPH SIEWICK DR. SUITE 404/402, FAIRFAX , VA 22033

(703)620-8900 FAX : (703)620-2288

ELECTRONIC SIGNATURES

By typing your name on the signature lines of this document and sending it to us electronically, you are signing this Agreement electronically. You agree your electronic signature is the legal equivalent of your manually/handwritten signature on this Agreement. By typing your name on the signature line, you consent to the legally binding terms and conditions of this Agreement. You further agree that your signature on this document (hereafter referred as your "E-Signature") is as valid as if you signed the document in writing. You also agree that no certification authority or other third party verification is necessary to validate your E-Signature, and that the lack of such certification or third party verification will not in any way affect the enforceability of your E-Signature or any resulting agreement between you and The Clinical Skin Center of Northern Virginia, PLLC. You are also confirming that you are the person or their authorized representative entering into this Agreement.

Definitions: "Electronic" means technology having electrical, digital, magnetic, wireless, optical, electromagnetic, or similar capabilities. "Electronic Signature" means and electronic symbol or process attached to, or logically associated with, a record and used by a person with the intent to sign the record.

The Clinical Skin Center of Northern Virginia, PLLC
3700 Joseph Siewick Drive, Suite 402/404 Fairfax, VA 22033
Tel: 703-620-8900 Fax 703-620-2288 www.ClinicalSkinCenter.com

Patient Authorization and Informed Consent for Telemedicine

Patient Name: _____ Date of Birth: _____

Pharmacy Name, Address, and Phone number: _____

1. I understand that my health care provider will engage with me in a telemedicine consultation.
2. My health care provider has explained to me how the video, audio and still photographic conferencing technology will be used to affect such a consultation. I understand that this will not be the same as a direct patient/healthcare 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 understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my health care provider and consulting health care provider in order to provide medical support and/or technical assistance. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room: and or (3) terminate the consultation at any time.
5. During the public health crisis, by order of Department of Health Human Services HHS, a limited waiver on HIPAA Privacy rules is in effect. This allows medical practices to facilitate easier and better communication with patients and enable widespread use of telemedicine consultation. The information contained in this transmission may contain privileged and confidential information, including patient information protected by federal and state privacy laws. This health information may not be protected under the Health Insurance Portability and Accountability Act (HIPAA) and may not be 100 percent secure.
6. I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a telemedicine consultation. I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting health care provider.
7. I understand that the practice of Dermatology often involves physical tests which may only be conducted during in-person visits in our office. I agree that is my responsibility to follow-up in a timely manner for any tests or biopsies as ordered or directed by my provider. I understand that any remaining medical concerns, persistent or worsening lesions, rashes or symptoms require further prompt evaluation in-person.
8. I understand that billing will occur from my practitioner just as it would for an in-office visit and I will be responsible for any applicable copays and/or deductibles as determined by my insurance carrier.
9. I had the opportunity to ask questions in regard to this form and this procedure. My questions have been answered to my satisfaction and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

_____ _____
Patient's/parent/guardian signature Date

_____ _____
Provider Date