MyOr Diagnostics Ltd. Consent for Telehealth Consultation

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CONSENT FOR TELEHEALTH CONSULTATION

1. I understand that my healthcare provider wishes me to engage in a telehealth consultation.
2. My health care provider explained to me that the telehealth technology used to conduct such a consultation will not be the same as a direct client/health care provider visit because I will not be in the same room as my provider.
3. I understand that a telehealth consultation has potential benefits, including easier access to care and the convenience of meeting from a location of my choosing.
4. I understand this technology has potential risks, including interruptions, unauthorized access, and technical difficulties. I understand that my healthcare provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
5. I have had a direct conversation with my provider, during which I had the opportunity to ask questions regarding this procedure. 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.

CONSENT TO USE TELEHEALTH SERVICES BY PRACTICE BETTER

Telehealth by Practice Better is the technology service we will use to conduct telehealth videoconferencing appointments. It is simple to use and no passwords are required to log in. By signing this document, I acknowledge:

1. Telehealth by PracticeBetter is NOT an Emergency Service, and in the event of an emergency, I will use a phone to call 911.
2. Though my provider and I may be in direct, virtual contact through the Telehealth Service, neither PracticeBetter nor the Telehealth Service provides any medical or healthcare services or advice, including emergency or urgent medical services.
3. The Telehealth by Practice Better Service facilitates videoconferencing and is not responsible for delivering any healthcare, medical advice, or care.
4. I do not assume that my provider has access to any or all of the technical information in the

Telehealth by PracticeBetter Service – or that such information is current, accurate or up-to-date. I will not rely on my health care provider to have this information in the Telehealth by PracticeBetter Service.

5. To maintain confidentiality, I will not share my telehealth appointment link with anyone who is unauthorized to attend the appointment.

By signing this form, I certify:

- I have read or had this form read and/or had this form explained to me.
- I fully understand its contents, including the procedure's risks and benefits of the procedure(s).
- I have been given ample opportunity to ask questions and any questions I have had have been answered satisfactorily.

BY SIGNING BELOW, I AM AGREEING THAT I HAVE READ, UNDERSTOOD, AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Client

X

Print name: **Date:**