Northeast Georgia Diagnostic Clinic, LLC
Informed Consent for Communication Technology-Based Services

By signing this Agreement, you consent to Northeast Georgia Diagnostic Clinic, LLC, (referred to as "Provider"), providing communication technology-based services (referred to as "CTBS") to you as more fully described below. CTBS enables health care providers at different locations to meet with patients and share individual patient medical information for the purpose of improving patient care. CTBS includes access to a health care provider in Provider's practice to address and manage your healthcare needs. The Provider will discuss with you the specific services that will be available to you and how to access those services.

Provider's Obligations. When providing CTBS, the Provider will:

- Explain to you (and your caregiver, if applicable), and offer to you a consultation. Provider does not assume any responsibility for continued medical care or treatment that is not included in the CTBS.
- Provide to you a written or electronic copy of your care plan.

Beneficiary Obligations. You have the following rights with respect to CTBS:

- You have the right to stop CTBS at any time by revoking this Agreement. You may revoke this agreement verbally (by calling _____) or in writing (to _____). Upon receipt of your revocation, the Provider will give you written confirmation (including the effective date) of revocation. Absent revocation, this Agreement will remain in place for one (1) year.
- You understand that CTBS is based on the information provided by you and, in the absence of a physical evaluation, the Provider may not be aware of certain facts that may limit or affect his or her assessment or diagnosis of your condition and recommended treatment.

By signing this Agreement, you agree to the following:

- You consent to the Provider rendering CTBS to you and you understand that CTBS is different from a face-to-face examination. Provider is providing these services based upon verbal and written information available during the visit. Accordingly, the treatment and diagnoses you will receive is provisional.
- You understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies you will be disclosed without you consent.
- You authorize electronic communication of your medical information with other treating providers as part of coordination of your care.
- You understand that cost-sharing will apply to CTBS, so you may be billed for a portion of CTBS even though CTBS will not involve a face-to-face meeting with the Provider.

I have read and understand the information provided above regarding CTBS, have discussed it with Provider and all my questions have been answered to my satisfaction. I hereby give my informed consent for the use of CTBS in my medical care.

Beneficiary or Beneficiary's Representative and/or Caregiver (if applicable)

Signature: _____ Print Name: _____ Date:_____

Witnessed By:

Signature: _____ Print Name: _____ Date:_____