CHICAGO GASTRO TELEMEDICINE AGREEMENT

Telemedicine involves the use of electronic communication to enable healthcare providers to treat patients remotely and improve patient care. I understand that I will be engaging with my healthcare provider at Chicago Gastro LLC in a telemedicine consultation. Details of my medical history, examination, procedure results, etc will be discussed over the telephone and/or video conference. I understand that there are potential risks to technology, including interruptions, and potential 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. 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 will not be conducted.

I understand that Chicago Gastro will charge my insurance company for my telemedicine visit. I understand that I am responsible for any annual deductible, co-payment, coinsurance, and charges for non-covered visits. I will pay my patient balance in-full within 30 days of receipt of my bill or I will be sent to Collections with a 30% Premium applied to my patient balance.

I hereby acknowledge that I have read this form and authorize this telemedicine arrangement.

Patient Name (Print): _____________________________ Date of Birth: _____________________

Patient Signature: ________________________________ Date: ____________________________