MARK W. WILSON, MD, PC
330 WEST 58TH STREET, SUITE 313
NEW YORK, NEW YORK 10019

March 15, 2020

CONSENT FOR TELEHEALTH (VIDEO) CONSULTATION

1. I understand that Dr. Wilson is able to engage in telehealth consultation(s)/session(s).
2. Dr. Wilson explained to me how the video conferencing technology that will be used to affect such a consultation will not be the same as a direct client/healthcare provider visit due to the fact that 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 there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand Dr. Wilson 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 been made aware I can have a direct conversation with Dr. Wilson, during which I have the opportunity to ask questions in regard to this procedure.
6. I have been made aware that if I would rather meet in person, I can discuss this with Dr. Wilson.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of the procedure(s).

SIGNATURE OF CLIENT (if 18 yo or older)**:** **X**_____

Name of **CLIENT** (if 18 yo or older)**:** _____

SIGNATURE OF CAREGIVER (if under 18 yo): **X**_____

Name of **CAREGIVER** (if under 18 yo): _____

Date: / /20