Madhureeta Achari, MD
Neurology/Neuroimaging/Neurophysiology
Nutritional Neurology

Diplomate, American Board of Psychiatry & Neurology
Diplomate, United Council of Neurological Specialties

VIRTUAL VISIT CONSENT FORM

Patient Name: **Date:**

Patient D.O.B

I hereby authorize **Madhureeta Achari, MD** and **Integrated Neurology, PA** to use the **Virtual Visit** (Facetime, Skype WhatsApp or Zoom) platform(s) for evaluating, testing and diagnosing my medical condition.

I understand that technical difficulties may occur before or during the **Virtual Visit** and that my appointment may not begin at the appointed time.

I accept that **Dr. Achari** can conduct interactive sessions using the above formats; however, if Internet speed, or other technical issues arise, **Dr. Achari** may call to conduct a phone visit (for established patients only).

I acknowledge that my **Virtual Visit** is private, and that it is not recorded in any way other than written notes by **Dr. Achari** within my patient chart.

Signature of Patient:

FOR CAREGIVERS:

I consent to the terms listed above and agree to be present during the Virtual

Visit between (Patient): and Dr. Achari.

Signature of Caregiver: