United Neuroscience, Inc.

9330 Stockdale Highway, Suite 200, Bakersfield, CA. 93311, United States.

Patient Name: _____
Date of Birth: _____
Date: _____

1. Telehealth Services Overview

I understand that **United Neuroscience Inc** provides healthcare services using telehealth, which includes secure video, telephone, and/or electronic communications that allow me to consult with my provider without being physically present. I understand that not all visits can be telehealth visits.

2. Nature of Care

I understand that my provider at United Neuroscience Inc may:

- Evaluate, diagnose, and provide treatment recommendations
- Prescribe medications when appropriate
- Recommend follow-up care or referrals

I acknowledge that telehealth visits may not fully replace in-person care for certain conditions.

3. Risks and Limitations

I understand the potential risks of telehealth include:

- Technical difficulties (e.g., interruptions, poor video/audio quality)
- Limited ability to perform a full physical examination
- Potential delays in diagnosis or treatment due to these limitations

4. Privacy and Confidentiality

United Neuroscience Inc takes reasonable steps to protect my privacy and confidentiality in accordance with applicable laws, including the Health Insurance Portability and Accountability Act.

I understand that:

- My medical information will be transmitted electronically
- While safeguards are in place, there is a small risk of data breach
- I am responsible for choosing a private location for my telehealth visit

5. Patient Rights

I understand that:

- I may withdraw my consent to telehealth services at any time without affecting my access to future care
- I have the right to request an in-person visit instead of telehealth
- I may ask questions about telehealth services before or during my care

6. Consent to Telehealth Services

By signing below (or providing verbal/electronic consent), I:

- Voluntarily consent to receive healthcare services via telehealth from United Neuroscience Inc
- Confirm that I have read and understand this form
- Have had the opportunity to ask questions and have received satisfactory answers

Patient Signature: _____
Date: _____

(If applicable) Parent/Guardian Name: _____
Signature: _____

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