CONSENT FORM FOR LIVE CONSULTATION

Patient name	
Contact No	
Email	
Passport No	
Patient ID(if registered patient)	

We kindly request you to sign the consent form below before starting the live consultation and return it to the hospital via email.

I authorize the clinic to discuss my medical information as deemed necessary, with no guarantees for my treatment results.

I agree to pay all charges for services regardless of insurance coverage.

- **I am aware of the potential risks associated with live consultations and the use of technology.**
- **Insufficient information transmission, such as low image resolution, may impede physicians' ability to make informed decisions.**
- **Delays in medical evaluation and treatment may occur due to equipment deficiencies or malfunctions.**
- **In rare instances, security protocol could fail causing a breach of privacy and/ or confidentiality of personal medical information.**
- **In rare cases, a lack of access to complete health records may result in adverse drug interactions, allergic reactions, or other judgment errors.**

I am fully aware of all the potential risks, consequences, and benefits associated with participating in a live consultation.

I agree to visit the clinic if the physician advises a physical visit for complete treatment.

I agree to participate in the live consultation for the service(s)/procedure(s) mentioned above.

Patient Name

Patient Signature

Date

La Vie Avenue
Keep Sparkling