



## Online Diabetes & Metabolic Management Program Contract

Welcome to the Endocrine Metabolic Medical Center Online Diabetes and Metabolic Management Program. A full description of the program can be found on the EMMC website ([www.endocrinemetabolic.com](http://www.endocrinemetabolic.com)). We are looking forward to getting started!

If you have not been to EMMC as an established patient, we will need to partner with a general physician in your community. This physician must be willing to work with EMMC staff to round out the legal and ethical points of diabetes and metabolic syndrome care through the Internet (telemedicine). Many physicians are initially unsure of the need for telemedicine but when they have seen the positive impacts on their patients, most support their involvement in high tech care.

EMMC requires a partnership with your physician to provide the best diabetes care. EMMC will suggest adjustments and changes to medications, and request laboratory tests and x-rays as needed for your care. You will return to your physician's office for general physical exams and blood pressure checks. Your interaction with your doctor and the long-term relationship you have developed will not change. Through the Online Diabetes and Metabolic Management Program, you will have continuous consultation with EMMC and your physician will be kept informed of your online health plan. EMMC's information about your health will be accessible to you and your physician.

To accomplish this ongoing cooperation, you and your doctor must acknowledge your participation in the EMMC Online Diabetes and Metabolic Management Program, by signing this consent form below. Participants may withdraw at any time by written notification to the Endocrine Metabolic Medical Center.

The parties signed below agree to participate in the Online Diabetes and Metabolic Management Program from the Endocrine Metabolic Medical Center.

A handwritten signature in black ink, appearing to read "Prendergast J.", written over a horizontal line.

J. Joseph Prendergast, MD

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Print Physician Name

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date



## Telemedicine Consent Form

I hereby authorize Dr. J. Joseph Prendergast to use telemedicine in the course of my diagnosis and treatment. I understand that telemedicine involves the communication of my medical information, both orally and visually, to physicians and other health care practitioners located in other parts of the state or outside of the state.

I understand I have all the following rights with respect to telemedicine:

1. **Free Choice.** I have the right to withhold or withdraw my consent to telemedicine at any time without affecting my right to future care or treatment and without risking the loss of my health coverage.
2. **Access to Information.** I have the right to inspect all medical information transmitted during a telemedicine consultation, and may receive copies of this information for a reasonable fee.
3. **Confidentiality.** I understand that the laws that protect the confidentiality of medical information apply to telemedicine, and that no information or images from the telemedicine interaction which identify me will be disclosed to other entities without my consent. I understand EMMC may use my data for research purposes, but my identity will in no way be linked to this data.
4. **Potential Risks.** I understand that there are risks from telemedicine, including the following: 1) Loss of records from failure of electronic equipment, 2) power failures with loss of communication, 3) invasion of electronic records by outsiders (hackers). Finally, I understand that it is impossible to list every possible risk, that my condition may not be cured or improved, and in rare cases, may get worse.
5. **Consequences.** I understand that, by having my consent to telemedicine, my physician will communicate medical information concerning me to physicians and other health care practitioners located in other parts of the state or outside the state.
6. **Benefits.** I understand that I can expect the following benefits from telemedicine, but that no results can be guaranteed or assured: 1) Reduced visit time, 2) rapid innovation of treatments, 3) focused information.

I have read and understand the information provided above, I have discussed it with my physician or my physician's designee, and all my questions have been answered to my satisfaction.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

### **Physician Section**

I am willing to work with Dr. J. Joseph Prendergast at Endocrine Metabolic Medical Center in cooperation with my patient (signature above) regarding his/her medical care.

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

Please print this page and mail or fax it to:

Endocrine Metabolic Medical Center  
350 Cambridge Ave., Suite 250  
Palo Alto, CA 94306  
Fax: (650) 566-9825