SAUDI GERMAN HOSPITALS UAE	Consent for Live Consultation	**Patient Name:** **SGH File No.:** (***If SGH Registered patient)***

Emirates ID No: _____ Date of Birth: _____

Insurance Card No. (if applicable) _____

We are requesting you to kindly sign the below consent prior to starting the Live consultation and return it back to the hospital on E- mail:

I hereby authorize Saudi German Hospital to discuss my medical condition, care plan, treatment and medication regimen, be deemed necessary with no guarantees about the results of my treatment.

I consent to pay all charges of the services that will be rendered to me according to hospital price list even if my insurance provider will reject to pay.

I am aware of the Possible Risks of the live consultation and the potential risks associated with the use of technology, which may include, but not limited to the following:

a. Information transmission may not be sufficient (e.g. poor resolution of images) to allow proper decision making by the consulted physician.

b. Delays in medical evaluation and treatment could occur due to deficiencies or failure of equipment.

c. In rare instances, security protocol could fail causing a breach of privacy and/ or confidentiality of personal medical information.

d. In rare cases, a lack of access to complete health records may result in adverse drug interactions, allergic reactions, or other judgement errors.

I am aware of all the risks, consequences and the benefits of live consultation.

I agree to visit Saudi German Hospital in case the physician will further advice for a need to be physically available in order to avail the best and complete treatment according to my condition.

☐ I **agree** to participate in the live consultation for the service(s)/procedure(s) mentioned above. **Signature:** _____ If signed by someone other than the patient, indicate relationship: **Date:** **Time:**	☐ I do not **agree** to participate in the live consultation for the service(s)/procedure(s) mentioned above. **Signature:** _____ If signed by someone other than the patient, indicate relationship: **Date:** **Time**:
Witness Name: **Date:** **Time:**	