Consent to participate in a telemedicine appointment

1. I understand that Dr. Orton of Green Mountain Pediatrics, PC, wishes me to engage in a telemedicine consultation using Doxy.me for myself/my child.

2. She has explained to me how the Doxy.me video conferencing technology will be used to affect such a consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as Dr. Orton.

3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that Dr. Orton or I can discontinue the telemedicine consult/visit if it is felt that the Doxy.me videoconferencing connections are not adequate for the situation.

4. I understand that if others are present during the consultation other than Dr. Orton, they will maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room: and or (3) terminate the consultation at any time.

5. I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a Doxy.me telemedicine consultation.

6. I have had a direct conversation with Dr. Orton, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

By signing this form, I certify:

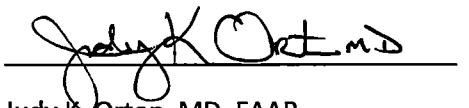
* That I have read or had this form read and/or had this form explained to me

* That I fully understand its contents including the risks and benefits of the procedure(s).

* That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

_____ for _____ Date: _____

Patient (if over 18 yrs.)/Legal Guardian Patient Name



Judy K. Orton, MD, FAAP

Expiration, when revoked in writing by patient/legal guardian