Johns Hopkins Division of Cardiology
Genetic Counseling Telemedicine Program

Patient Disclaimer

By using the Johns Hopkins Division of Cardiology Genetic Counseling Telemedicine service, you agree to abide by the Terms and Conditions posted at our website www.arvd.com/telemedicineconsult, including particularly the terms and conditions below:

CONSULTATIVE SERVICE
The service provided through the Johns Hopkins Division of Cardiology Genetic Counseling Telemedicine Program is different from an in person visit with a genetic counselor and physician here at Johns Hopkins Hospital (JHH). This visit will include genetic counseling, discussion of genetic testing, and ordering of genetic testing as indicated. Because we will not have the benefit of ordering follow up cardiac testing here at JHH, recommendations and results of testing will be shared by the genetic counselor with your local physician. A local physician is required to receive the results. By deciding to engage in this service, you acknowledge and agree that you are aware of this limitation and agree to assume the risk of this limitation. In person visits or follow up visits are available at JHH at any time by calling 410-502-7161 to schedule.

By requesting a Genetic Counseling Telemedicine visit, you acknowledge and agree that:
- This visit will be for genetic counseling and testing if indicated only.
- The Genetic Counseling telemedicine visit is not intended to replace a full medical evaluation for ARVD/C with a physician.
- It is the responsibility of your local physician to direct your follow up care based on receiving the results of your genetic testing. We will not be able to order any follow up cardiac testing without seeing you in person at JHH.
- At any time, you may schedule an in person visit for evaluation at JHH.

By engaging in our services, you acknowledge and agree to assume the risk of these limitations. You further understand that no warranty or guarantee has been made to you concerning any particular result or cure of your condition.

______________________________________________ / ____ / _____
Patient Signature  Date