PARTNERS IN CARE PEDIATRICS

TELEMEDICINE CONSENT FORM

1. I understand that my health care provider wishes me to engage in a telemedicine consultation.

2. I understand that video conferencing technology used 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 my health care provider.

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

4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes and telemedicine visit will be billed to my insurance

5. I understand the alternative to telemedicine will be coming to the office, and in choosing to participate in a telemedicine consultation, I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting health care provider.

6. I understand that Telemedicine consult time is based on availability of the physician and in case of urgent need for a consult it may be better to consider going to local urgent care or ER for faster access.

7. I understand that billing will occur from both my pediatrician office

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 using telemedicine.

Patient's/parent/guardian:

signature ______________________________ Date_____________________