INFORMED CONSENT FOR TELEMEDICINE SERVICES

Patient Name: _____

Location of Patient: _____

1. I understand that my healthcare providers at Pediatric & Adolescent Medicine LLP have made themselves available to engage in a telemedicine consultation.

2. I understand that such a consultation will not be the same as a direct patient/healthcare provider visit due to the fact that I/my child will not be in the same room as my healthcare provider.

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

4. I understand that my/my child's healthcare information may be shared with other individuals for scheduling and billing purposes.

5. I have had the alternatives to a telemedicine consult explained to me and I am choosing to participate in a telemedicine consult. I understand that there are inherent limitations to a telemedicine consultation and delays in medical evaluation and treatment could occur. I understand that some parts of an in person examination cannot be performed in a telemedicine consultation and a telemedicine consultation may not be a substitute for a required in person examination. If a direct physical examination or tests are required, alternatives will be discussed with me by my healthcare provider.

6. I understand the billing will occur from my healthcare provider.

7. I have had a direct conversation with my healthcare provider during which I had the opportunity to ask questions regarding the expected benefits and possible risks of a telemedicine consultation.

I have read and understand the information provided above regarding telemedicine, have discussed it with my healthcare provider, or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my/my child's medical care.

Signature of Patient or Authorized Person: _____

If Authorized Signer, relationship to patient: _____

Dated: _____