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TELEHEALTH INFORMED CONSENT

Telehealth is healthcare provided by any means other than a face-to-face visit. In telehealth services, medical and mental health information is used for diagnosis, consultation, treatment, therapy, follow-up and education. Health information is exchanged interactively from one site to another through electronic communications. Telephone consultation, videoconferencing, transmission of still images, e-health technologies, patient portals, and remote patient monitoring are all considered telehealth services.

I understand that telehealth involves the communication of medical/mental health information in an electronic or technology-assisted format.

I understand that I may opt out of the telehealth visit at any time. This will not change my ability to receive future care at this office.

I understand that electronic communication should never be used for emergency communications or urgent requests. In the event of an emergency, I must contact emergency 911 services in my community.

I understand that telehealth billing information is collected in the same manner as a regular office visit. My financial responsibility will be determined individually and is governed by my insurance carrier(s). It is my responsibility to check with my insurance plan to determine coverage.

I understand that all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include but are not limited to:

- *It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures.*
- *Electronic systems that are accessed by employers, friends, or others are not secure and should be avoided. It is important for me to use a secure network.*
- *Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures.*

I understand that Skype, Facetime, or a similar service may not provide a secure HIPAA-compliant platform, but I willingly and knowingly wish to proceed.

I agree that information exchanged during my telehealth visit will be maintained by the doctors, other healthcare providers, and healthcare facilities involved in my care.

I understand that I must take reasonable steps to protect myself from unauthorized use of my electronic communications by others.

The healthcare provider is not responsible for breaches of confidentiality caused by an independent third party or by me.

I understand that electronic communication cannot be used for emergencies or time-sensitive matters.

I understand and agree that a medical evaluation via telehealth may limit my healthcare provider's ability to fully diagnose a condition or disease. I agree to accept responsibility for following my healthcare provider's recommendations, including further diagnostic testing or an in-office visit.

I understand the inherent risks of errors or deficiencies in the electronic transmission of health information and images during a telehealth visit.

I understand that electronic communication may be used to communicate highly sensitive information related to a diagnosis.

I understand and agree to all of the above and agree to receive healthcare for my child via telehealth for all telehealth visits scheduled. My authorization below will apply to all telehealth visits I schedule with Family Choice Pediatrics, Inc. To withdraw my consent, I must provide written notification to Family Choice Pediatrics, Inc. of my decision to withdraw consent to receive telehealth.

Patient's Name: _____ Date of Birth: _____
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Patient's Name: _____ Date of Birth: _____
Patient's Name: _____ Date of Birth: _____

Parent's, Legal Guardian's Name (Print):_____

Parent's, Legal Guardian's Signature: _____Date: _____