FALL HILL
PEDIATRICS

Consent to Participate In Telemedicine Consultation

Patient Name: _____ Date of Birth: _____

1. I understand that my/my child's health care provider wishes me to engage in a telemedicine consultation.
2. I understand that if my insurance is not in effect on the date(s) of service or my insurance denies a claim, for any reason, I will be financially responsible for all total amounts due and I agree to pay the total indebtedness to Fall Hill Pediatrics.
3. My/my child's health care provider has explained to me how the video conferencing 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/my child will not be in the same room as my/my child's health care provider.
4. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my/my child's 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.
5. I understand that in very rare instances, security protocols could fail, causing breach of privacy of personal medical information.
6. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my/my child's health care provider and consulting health care provider in order to operate the video equipment. The above mentioned people will all 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/my child; (2) ask non-medical personnel to leave the telemedicine examination room; and or (3) terminate the consultation at any time.
7. I have had the alternatives to telemedicine consultation explained to me, 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.
8. I understand that billing will occur from my/my child's practitioner and a claim will be submitted to my insurance company.
9. I have had a direct conversation with my/my child's doctor's office, during which I had the opportunity to ask questions in regard to this consultation.
10. I understand that medicine is not an exact science and there are no guarantees that can be made regarding outcomes and results of these examination and treatments.
11. I understand that this consent can be revoked at any time via a written request.

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.

Parent/Legal Guardian Printed Name	Parent/Legal Guardian Signature	Date/Time