1. I authorize STEP BY STEP PEDIATRICS to allow me/the patient to participate in a telemedicine (video/audio/text conferencing) service with SPRUCE HEALTH.

2. The type of service to be provided by via telemedicine is: Pediatrics.

3. I understand that this service is not the same as a direct patient/healthcare provider visit, because I/the patient will not be in the same room as the healthcare provider performing the service. I understand that parts of my/the patient's care and treatment which require physical tests or examinations may be conducted by providers and their staff at my/the patient's location under the direction of the telemedicine healthcare provider.

4. My/the patient's physician has fully explained to me the nature and purpose of the videoconferencing technology and has also informed me of expected risks, benefits and complications (from known and unknown causes), attendant discomforts and risks that may arise during the telemedicine session, as well as possible alternatives to the proposed sessions, including visits with a physician in-person. The attendant risks of not using telemedicine sessions have also been discussed. I have been given an opportunity to ask questions, and all of my questions have been answered fully and satisfactorily.

5. I understand that there are potential risks to the use of this technology, including but not limited to interruptions, unauthorized access by third parties, and technical difficulties. I am aware that either my/the patient's healthcare provider or I can discontinue the telemedicine service if we believe that the video/audio/text conferencing connections are not adequate for the situation.

6. I understand that the telemedicine session will be transcribed and placed in my/patient's chart.

7. I agree to permit my/the patient's healthcare information to be shared with other individuals for the purpose of scheduling and billing. I agree to permit individuals other than my/the patient's healthcare provider and the remote healthcare provider to be present during my/the patient's telemedicine service to operate the video equipment, if necessary. I further understand that I will be informed of their presence during the telemedicine services. I acknowledge that if safety concerns mandate additional persons to be present, then my or guardian permission may not be needed.

8. I acknowledge that I have the right to request the following:
   a. Omission of specific details of my/the patient's medical history/physical examination that are personally sensitive, or
   b. Asking non-medical personnel to leave the telemedicine room at any time if not mandated for safety concerns, or
   c. Termination of the service at any time.

9. It is the responsibility of the telemedicine provider to conclude the service upon termination of the connection.

10. I/the patient understand(s) that my/the patient's insurance will be billed by the local healthcare provider for telemedicine services. I/the patient understand(s) that if my insurance does not cover telemedicine services I/the patient will be billed directly by the local healthcare provider for the provision of telemedicine services.

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11. My/the patient's consent to participate in this telemedicine service shall remain in effect for the duration of the specific service identified above, or until I revoke my consent in writing.

12. I/the patient agree that there have been no guarantees or assurances made about the results of this service.

13. I confirm that I have read and fully understand the above All blank spaces have been completed prior to my signing. I have crossed out any paragraphs or words above which do not pertain to me.

Patient name _____ Cellphone # _____ Email Address _____

Patient/Parent/Guardian Signature _____ Printed Name _____

Relationship to Patient (if required) _____ Date _____

Witness _____ Date _____

*The signature of the patient must be obtained unless the patient is a minor unable to give consent or otherwise lacks capacity.

I hereby certify that I have explained the nature, purpose, benefits, risk of, and alternatives to (including no treatment) the proposed procedure, have offered to answer any questions and have fully answered all such questions. I believe that the patient/parent/guardian fully understands what I have explained and answered.

Provider's Signature _____ Date _____

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