PARKSIDE PEDIATRICS, S.C.
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TELEMEDICINE PATIENT CONSENT FORM

_____ _____
Patient Name Date

_____
Parent or Guardian Name (if applicable)

This form and your discussion with your healthcare professional are intended to help you make an informed decision about your Telemedicine Appointment where healthcare is provided through electronic communications. This health information may be used for diagnosis, consultation, treatment, therapy, follow up, or education. Telemedicine Appointments should not be used for emergency communications, life threatening conditions, or urgent requests. In signing this document, I acknowledge and agree with the following:

1. I understand that I will not be physically in the same room as my healthcare professional and that my healthcare professional will be using electronic communications technology which may include telephone consultation, videoconferencing, and transmission of still images.

2. I understand that it is my important job to provide an accurate and complete medical history, including all relevant past and present medical conditions, prescription and non-prescription medications, any allergies, recreational drug use, and pregnancy (if applicable).

3. Limitations that may exist with a virtual visit include that I may not be able to receive treatment or diagnosis for the condition which prompted the Telemedicine Appointment. I understand that in some instances, face to face follow up care may be necessary for further evaluation.

4. I understand that there may be potential risks related to the use of this technology, including interruptions and technical difficulties, poor image or sound quality, the inability to conduct certain tests or assessments, delays in treatment due to deficiencies of the technology used, and a lack of access to all relevant medical records which could result in adverse drug interactions or other errors in professional opinion. My healthcare professional will discuss alternate options if it is determined that the electronic communications are not adequate for the situation.

5. An additional risk inherent to the use of technology is unauthorized access or disclosure of my medical information to someone other than the intended party. I understand that my healthcare professional will disclose the type of technology that will be utilized and my decision to proceed will indicate my consent.

6. I understand that others may be present during the encounter, such as a consulting healthcare professional or non-medical personnel assisting in the operation of the telemedicine technology, and I consent to their presence.

7. I understand that my healthcare information may be shared with other individuals for the purposes of treatment, payment, and healthcare operations, such as scheduling, billing and continuity of care.

8. I understand that recording of this visit is prohibited, but that I have a right to inspect or obtain a copy of my medical records, or both, after the encounter.

9. I understand that I may withhold or withdraw my consent to using Telemedicine at any time. I also understand that my refusal or withdrawal will not affect my ability to receive future care or treatment.

10. Although Telemedicine Appointments may be reimbursed by my Insurance, I understand that I am responsible for any out of pocket costs such as coinsurances or copayments that may apply.

11. At any time I may ask questions about my Telemedicine Appointment and the associated risks, benefits, and practical alternatives to this type of encounter.

By signing this document, I acknowledge and accept the possible risks and agree to proceed with Telemedicine Appointments when clinically appropriate.

_____ _____

Patient or Legal Representative Signature Date

_____ _____

Printed Name Relationship