AR TEXAS PEDIATRICS
Health is LIFE

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Telehealth Informed Consent Form

I understand that my Pediatrician/AR Texas Pediatrics, Dr. Aseema Raoshan, MD, or/and any other Providers in office is allowing me to have a telemedicine/tele visit consultation for my child/children mentioned below.

This means that I and/or my healthcare provider or designee will through interactive video/and/or Phone connection, be able to consult with the Doctor, and/or Providers about my child's condition.

My healthcare provider has explained to me how the telemedicine technology will be used to do such a consultation.

Benefits:

The benefits of a telemedicine consultation are:

1. You may not need to travel to the consult location.
2. You have access to a Pediatric office through this consultation.
3. Other: Emergency due to Covid 19 crisis March 13, 2020.

Possible Risks:

Although rare, there are potential risks associated with the use of telehealth. These risks include, but may not be limited to:

1. Information transmitted may not be sufficient (e.g. poor connection) to allow for appropriate clinical decision making by the Treatment Provider and consultant(s);
2. Delays in evaluation and treatment could occur due to technical deficiencies or failures;
3. The transmission of client's clinical information could be interrupted by unauthorized persons; and/or the electronic storage of my clinical information could be accessed by unauthorized persons; and
4. A lack of access to complete clinical records may result in judgment errors.

I give my consent for me and my child/children to be interviewed by the consulting health care provider. I also understand other individuals may be present to operate the video equipment and that they will take reasonable steps to maintain confidentiality of the information obtained.

I understand that a limited physical examination will take place during the videoconference and that I have the right to ask my healthcare provider to discontinue the conference at any time. I understand that some parts of the exam may be conducted by individuals at my location at the direction of the consulting health care provider.

I authorize the release of any relevant medical information about me/my child to the consulting health care provider, any staff the consulting health care provider supervises, third party payers and other healthcare providers who may need this information for continuing care purposes.

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AR Texas Pediatrics will send the claim to my insurance,
Copays and deductible is parent responsibility as per my insurance plan.
Office may collect copay and/or deductible ahead of consultation/visit time.

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of clinical information also apply to telehealth. I understand that the information disclosed by me during the course of my treatment is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including but not limited to:
    a. Information demonstrating a probability of imminent physical injury to myself or others;
    b. suspicion of abuse of a child, elder, or individual with a disability; and
    c. If my clinical records are subpoenaed by a judge.
2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that I may expect the anticipated benefits from the use of telehealth in my child/children's care, but that no results can be guaranteed or assured.
4. I understand that in the event of an adverse reaction to the treatment, or in the event of an inability to communicate as a result of a technological or equipment failure, I shall seek follow-up care or assistance at the recommendation of my Treatment Provider.
5. I agree to provide verification of Texas residency and inform my Treatment Provider immediately of any changes to residency.
6. **For minors seeking treatment**: I agree to verify guardianship of minors seeking treatment by providing requested documentation.
7. I agree to secure a non-public environment for the duration of my telehealth sessions, including, but not limited to the following criteria: quiet, well-lit, enclosed area with minimal distractions and headphones/earbuds available. I will ensure confidentiality of my sessions by attending in a private setting.

<u>In case of life-threatening emergency, call 911 immediately.</u>

Client Consent to the Use of Telehealth

I have read and understand the information provided above regarding telehealth and understand I have the opportunity to discuss it with my Treatment Provider. I hereby give my informed consent for the use of telehealth for my child's or children's clinical care.
I hereby authorize AR Texas Pediatrics, PLLC, and its employees, agents and independent contractors, to use telehealth in the course of my child's or children's diagnosis and treatment.

Parent signature: _____ Date: _____

Patient name: _____ DOB: _____