Telemedicine Consent

Patient Name ______________________________ **Date** ______________________________

Parent/Guardian Name______________________________ **Phone Number** ______________

You or your child are consenting to have (a) clinical visit(s) using videoconferencing technology. You or your child will be able to see and hear the provider and they will be able to see and hear you, just as you were in the same room. You will be introduced to the provider and anyone else who is in the room with the provider. You may ask questions of the provider or any telemedicine staff in the room with you, if you are unsure of what is happening.

Reasonable and appropriate efforts have been made to ensure that this videoconference is secure, and no part of the encounter will be recorded. All existing confidentiality protections apply. Please note, not all telecommunications are recorded and stored. Additionally, dissemination to researchers or other entities or persons external to the patient-practitioner relationship of any patient-identifiable images or other patient-identifiable information from the telemedicine interaction shall not occur without your written consent.Your access to all medical information transmitted during a telemedicine interaction is guaranteed, and copies of this information are available at stated costs, which shall not exceed the direct cost of providing the copies.

If you are not comfortable with you or your child seeing a provider on videoconference technology, you may reject the use of the technology and schedule a traditional face-to-face encounter at any time.

There are potential risks associated with the use of telemedicine which include, but may not be limited to:

- A provider may determine that the telemedicine encounter is not yielding sufficient information (usually poor resolution of images) to make an appropriate clinical decision and recommend a face-to-face visit.
- Technology problems may delay medical evaluation and treatment for today's encounter.
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information.

By signing this form, you are affirming that you understand the following:

1. I understand that the laws that protect privacy and confidentiality of medical information also apply to telemedicine, and that no information obtained in the used of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withdraw my consent to the use of telemedicine in the course of my or my child's visit any time, without affecting my or their right to future care or treatment.
3. I also understand that if the provider believes I would be better served by a traditional face-to-face encounter, they may, at any time stop the telehealth visit and schedule a face-to-face visit.
4. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
5. I understand that Bright Future Pediatrics, LLC reserves the right to bill a telemedicine visit to your respective insurance company.
6. I understand that I am financially responsible for all charged incurred as a result of the treatment I or my child receives at the telemedicine clinic site.

Consent

I have read and understand the information provided above regarding telemedicine, and of my questions have been answered to my satisfaction. I hereby give my informed consent to the use of telemedicine in my or my child's care from Bright Future Pediatrics, LLC.

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Signature of the person to receive the vaccine(s) Date