Consent to Participate In a Telemedicine Consultation

Patient Name: ___________________________________

1. I understand that I am being asked to consent on behalf of my child to see a physician or nurse practitioner via telemedicine. This means that, through interactive video connection, I will be able to consult with my child's healthcare provider about my child's condition.
2. My child's healthcare provider has explained to me how the video conferencing technology will be used.
3. I understand that this consultation will not be the same as a direct patient/healthcare provider visit due to the fact that my child and I will not be in the same room as my child's healthcare provider.
4. I understand there are <u>potential risks</u> to using telemedicine technology, including:
   - Deficiencies or failures of the equipment (e.g., poor connection) may occur and result in delays in, or in extreme cases, cancellation of, medical evaluation or treatment.
   - Even the most secure security protocols can fail, causing a breach of confidential medical information.
   - I may be required to go to the location of the healthcare provider if it is felt that the information obtained via telemedicine was not sufficient for the consultation.
5. I understand that there are <u>benefits</u> to using telemedicine technology, including:
   - My child and I may not need to travel to the consult location.
   - Decreased risk of exposure to sickness to my child and to myself, and decreased risk of exposing others to sickness.
   - Ability to see a healthcare provider more rapidly with more rapid symptom relief.
6. I understand that I, or my child's healthcare provider(s), can discontinue the telemedicine consult at any time. Cancellation may be appropriate if it is felt that the videoconferencing connections are not adequate, or that the patient requires a face-to-face evaluation with the healthcare provider and patient in the same room.
7. I understand that my child's healthcare information may be shared with other individuals at the Clinic for scheduling and billing purposes. I also understand that individuals may be present during the consultation other than my child's health care provider in order to operate the video equipment. All individuals present will maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and will have the right to request the following:
   - to omit specific details of my child's medical history/physical examination that are personally sensitive;
   - to ask non-medical personnel to leave the telemedicine examination room; and/or
   - to terminate the consultation at any time.
8. I have had the alternatives to a telemedicine consultation explained to me, and I am choosing on behalf of my child to participate in a telemedicine consultation. I understand that some parts of the exam involving physical tests may be conducted by individuals at my child's location at the direction of the consulting healthcare provider.

9. I understand that the consultation will not be recorded or photographed.
10. In the event that my child is participating in a telemedicine consultation to obtain access to a specialist, I understand that my child's local health care medical records will contain a copy of any medical records regarding this consultation, and that my child's local healthcare providers will carry out the follow up treatment plan. I understand that these records will be sent to my child's regular treating physician, and that I can access this record by request at any time.

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 use of telemedicine; and
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.
- The purpose of this notice is to help you make an informed choice about whether you want your child to receive these items or services, even though your insurance plan may not pay for them and you may have to pay for them yourself. By signing below you agree that you take financial responsibility for all charges for items and services provided to your child regardless of whether your insurance pays for such charges or not.

____________________________ ____________ __________

Signature of Parent or Legal Guardian Date Time

** THIS FORM OR AUTHORIZATION FOR A TELEMEDICINE VISIT WILL NEED TO BE RETURNED TO THE CLINIC TO PROCEED WITH A TELEMEDICINE VISIT**
See options below on how to do this-

- Please print, sign and return this form before your telemedicine visit.
- If unable to do the option above, we need you to email customerservice@afkpeds.org and state that you have received the telemedicine consent form, understand it and want to proceed with the telemedicine visit. Then the actual form will need to be mailed to us to be put in your chart.