Pediatric Associates of Mt. Carmel Telehealth Consent Form

I (patient name) _____ agree to receive a pediatric office visit as a Telehealth service. I understand that the pediatrician from Pediatric Associates of Mt Carmel is located at another location (typically one of our three offices in Eastgate, Batavia or Loveland).

A Telehealth service means that my visit with a practitioner at the distant site will happen using special audiovisual equipment. This consent is valid for 12 months for follow up Telehealth services with the health care provider.

I also understand that:

- I can decline the Telehealth service at any time without affecting my right to future care or treatment.

- I may have to travel to see a health care practitioner in person if I decline the Telehealth service.

- The same confidentiality protections that apply at my other medical care also apply to the Telehealth service.

- I will have access to all medical information resulting from the Telehealth service as provided by law.

- The information for the Telehealth service (images that can be identified as mine or other medical information from the Telehealth service) cannot be released to researchers or anyone else without my additional written consent.

- I will be informed of all people who will be present at all sites during my Telehealth service.

- I may exclude anyone from any site during my Telehealth service.

- I may see an appropriately trained staff person or employee in person immediately after the Telehealth service if an urgent need arises or I will be told ahead of this if this is not available.

- I understand that my insurance will be billed for this visit and that I may be billed for what my insurance does not cover. I understand that if I have any questions about my billing, I need to talk with the provider's billing office. Therefore, by signing this consent, I am giving permission to release information to my insurance company or third party payer.

I have read this document carefully, and my questions have been answered to my satisfaction. I understand that this consent is valid for 12 months and will be renewed after _____.

_____ _____

Signature of Patient (or parent or legal guardian, if under 18 years old). Date

_____

If other than patient, relationship to patient

_____ _____

Witness Date

_____ copy given to patient _____ refused