Poole and Thomas Pediatrics

Telemedicine Informed Consent Form

Patient Information

Patient Name:_____DOB:_____

Introduction

You are going to have a clinical encounter using videoconferencing technology. You will be able to see and hear the provider and they will be able to see and hear you, just as if you were in the same room. The information gained from the encounter may be used for diagnosis, treatment, therapy, follow-up and/or education.

Benefits: Improved access to care by enabling a patient to remain safely in their home during the COVID19 pandemic and still obtain services from a provider at Poole and Thomas Pediatrics.

Possible Risks: 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 to make an appropriate clinical decision, which may require an in-office visit.
- Technology problems may delay medical evaluation and treatment.

By signing this form, I understand the following:

1. I understand that I have the right to withdraw my consent to the use of telemedicine during my care at anytime without affecting my right to future care or treatment.
2. I understand that if the provider believes I would be better served by a traditional office visit, the provider may at anytime stop the telehealth visit and schedule an office visit.
3. 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.
4. I understand that the laws that protect privacy and confidentiality of medical information also apply to telemedicine.
5. I understand that I will be responsible for any copayments that apply to my telemedicine visit.

Patient Consent to the use of telemedicine:

I have read and understand the information provide above regarding telemedicine at Poole and Thomas Pediatrics and that all my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my care.

I hereby authorize the providers at Poole and Thomas Pediatrics to use telemedicine in the course of diagnosis and treatment

Signature of patient (or authorized person)_____Date/Time_____

If authorized signer, relationship to patient_____