TELEHEALTH ACKNOWLEDGEMENT FORM

Patient's Name_____**DOB**_____

1. I understand that my healthcare provider, Dr. Mary Ann Jacob, has recommended to me that I engage in a telehealth appointment with her.

2. It has been explained to me how the telehealth technology will be used to connect me for a telehealth meeting with her. Telehealth appointments may be conducted by videoconferencing, video images, still (High quality photo) images, or by telephone conference. I understand that this appointment will not be the same as a direct patient/provider visit due to the fact that I will not be in the same room as Dr Jacob.

3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand Dr Jacob or I can discontinue the telehealth appointment if it is felt that the videoconferencing connections are not adequate for the situation. I understand that I can discontinue the telehealth appointment at any time.

4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present in order to operate the equipment. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence during the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telehealth room; and.or (3) terminante the telehealth appointment at any time

5. I have had the alternatives to a telehealth appointment explained to me.

6. In an emergency situation, I understand that Dr. Jacob may direct me to emergency medical services, such as an emergency room. Dr. Jacob's responsibility will end upon the termination of the telehealth connection.

7. I understand that billing for the telehealth consultation will occur. I can call if I have any questions regarding billing for this visit.

8. I have read this document carefully, and understand the risks and benefits of the telehealth appointment and have had my questions regarding the procedure explained and I hereby consent to participate in a telehealth appointment under the terms described herein.

_____ _____

Parent/Guardian signature Date and Time

_____ _____

Witness Signature Date and Time

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