# CARTERET CHILDREN'S CLINIC TELEHEALTH CONSENT FORM

## CONSENT FOR USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR PAYMENT, TREATMENT, MEDICATION HISTORY, AND HEALTHCARE OPERATIONS

I understand the purpose for this service is to seek medical advice and guidance for the care of my child who does not have an emergency condition. I also understand that at any time if I feel I cannot wait for a face to face visit or feel my child's condition has become an emergency then I will call 911 and/or seek emergent care. I consent to Telehealth services rather than face to face.

I understand that telemedicine is the use of video communication or telecommunication and other technologies by a healthcare provider at a remote location to deliver services to an individual located at a different physical location than the provider. I understand that, unlike a traditional in-person medical consultation, the provider at the remote location will not have the ability to use senses such as touch or smell in assessing my child's condition.

I understand that telemedicine provides benefits including improved access to specialists and an efficient means of assessment but, there are also a number of unique risks associated with telemedicine, which include, but are not necessarily limited to:

- Interruption or disconnection of the audio/video connection resulting in incomplete or delayed assessment.
- Delay in care resulting from communication service or equipment failure.
- Inadequate visual resolution resulting in incomplete assessment.
- Incomplete communication of medical history resulting in adverse drug interactions, allergic reactions, or other adverse result.

In addition to these risks, I understand that the remote provider evaluating my child does not have the opportunity to meet with my child in-person and must rely on information provided by me, my child, or the on-site provider. I will have my child's current weight and height available to give my provider at the time of the appointment. I understand and acknowledge that the remote provider cannot be responsible for advice, recommendations and/or decisions based on incomplete or inaccurate information provided by me, my child or others. I give my permission to have others in the room when necessary for purposes of safety or other health concerns or when developmental delays require input from caregivers.

Just as with a traditional in-person medical consultation, I understand that I will be financially responsible for any charges for my child's telemedicine visit. I understand that my telemedicine visit may not be covered by my insurance plan and I will be responsible for payment.

My child and I have had the opportunity to review this information. By signing this form, I indicate that I have chosen to proceed with the telehealth visit for my child.

I understand that the remote provider is a provider at **Carteret Children's Clinic**. **Carteret Children's Clinic** will maintain a record of this telemedicine visit in my medical chart and I may obtain a copy of that record as provided in the Notice of Privacy Practices.

I will be ready for the telehealth visit at the appointment time, in a private setting, where the visit can be completed without distractions. Any disclosure of protected information in my setting will be my responsibility.

I consent to the healthcare provider to provide healthcare services to my child via telemedicine. And can terminate services at any time. Until this consent is revoked by me, it will remain in effect. The provider may provide healthcare services to my child via telemedicine pursuant to this consent without the need for me to sign another consent form.

Patient Name: ______________________________ DOB: ______________

Parent/Guardian Signature: ______________________________ Date: ______________

Printed Name: ______________________________