WATERVILLE PEDIATRICS
295C Kennedy Memorial Dr. Ste. 1
Waterville ME 04901
207-873-5437

Consent for Telehealth

I. DESCRIPTION, PURPOSE AND BENEFITS

*For purposes of this consent, "my" means "my child", unless your child is legally able to provide consent for these services.

I have been informed that video conferencing equipment will be used to provide a telehealth encounter at home via real-time interactive services and also may include the use of certain technologies to collect images and data to assist in my evaluation, diagnosis and treatment. I also have been informed that the encounter will be somewhat different from an in-person patient encounter due to the fact that I will not be in the same room as my child's telehealth consulting physician or designee. I further understand that I will have an opportunity to speak with the physician or designee and ask questions.

I understand that individuals other than my child's healthcare providers may be present during the telehealth encounter in order to operate the video conferencing equipment, and that my child's protected healthcare information also may be shared for scheduling and billing purposes as such information is shared for in-person visits. I further understand that I will be informed of the presence of any non-medical personnel who may be present and will have the right to request the following:

i. Omit specific details of my medical history/physical examination that are personally sensitive to me if the non-medical personnel need to remain;
ii. Ask non-medical personnel to leave; and/or
iii. Terminate the telehealth encounter at any time.

I further understand that either my physician or designee or I can discontinue the telehealth encounter at any time if it is determined that the videoconferencing connections are not adequate to assess my particular medical situation in which case I will be referred to another healthcare provider for an in-person evaluation.

II. LIMITATIONS AND RISKS ASSOCIATED WITH THE TELEHEALTH CONSULT

I understand that certain limitations exist with a telehealth encounter including a provider's ability to perform a comprehensive physical assessment and certain diagnostic tests, as well as to obtain and transmit certain clinical findings via video/audio. I further understand that telehealth is not suitable to provide a diagnosis and treatment plan for every medical condition. Additionally, the treatment of certain medical conditions may require the use of equipment not available in a telehealth encounter. For these reasons, my particular medical needs may require an in-person encounter with a clinician and/or the need to undergo certain laboratory or other diagnostic tests. The physician performing the telehealth encounter or designee will inform me whether a telehealth encounter is sufficient to render a diagnosis and/or provide treatment recommendations, or if further evaluation of my medical condition is needed. I also have been informed that certain medications such as narcotics may not be prescribed during a telehealth encounter.

The physician performing the telehealth encounter or designee also has explained to me that the usual and most frequent risks associated with this type of encounter include: (i) interruptions to Internet access and/or technical difficulties which may affect the clinical information obtained and transmitted or prematurely end the encounter; (ii) unauthorized access to the videoconferencing equipment which may result in a breach of my protected health information; (iii) patient utilization of a third party connection to participate in the telehealth encounter at home which may become insecure resulting in a breach of my protected health information; (iv) the presence of third parties in my home who may overhear

the telehealth encounter which may result in a breach of my protected health information; and (v) the inadvertent transmission of images of third parties present in my home or of furnishings and personal possessions. In the event that interruptions to Internet access and/or technical difficulties occur, the physician performing this telehealth encounter or designee has explained the protocol to be followed.

III. **ALTERNATIVE COURSES OF TREATMENT**

The physician performing this telehealth encounter or designee has explained to me the reasonable alternative treatment or procedures and, as appropriate, their usual and most frequent risks. I understand that the alternative to a telehealth encounter is a visit to another healthcare provider for an in-person evaluation, diagnosis or treatment which may not occur as quickly as a telehealth encounter can be performed.

IV. BILLING FOR THE TELEHEALTH CONSULT

I understand that billing for this telehealth encounter will consist of a fee from the physician or designee performing the telehealth encounter or designee, and that billing statements will be mailed to me following the telehealth encounter with any remaining balances. If I have health insurance, I understand that I am financially responsible in the event that all or some payment is denied by my insurance carrier or other third parties who is responsible for payment. I also am responsible for those charges not covered by my insurance, such as deductibles, co-pays, or evaluations or treatment that are not included as an insurance benefit. This includes services rendered to me that may not meet medical necessity as defined by my insurance carrier.

I acknowledge that I have read this document carefully, that I understand the limited nature, benefits, risks and alternatives to this telehealth encounter at home, and that I have had ample time to ask questions and to consider my decision. I hereby consent to participate in the telehealth services described herein for purposes of evaluation, diagnosis and treatment consistent with the limitations of the available technology and my particular medical condition.

X	AM|PM	X
Signature of ❑ Patient ❑ Parent ❑ Guardian ❑ Authorized Representative	Date| Time	Witness Signature

Printed name of person signing on behalf of the patient: _____ Patient is a ❑ Minor or _____

Consent given by telephone/video ❑ Patient ❑ Other _____ Phone #_____

Printed name of interpreter _____ Reason ❑ Sign ❑ Language ❑ Other _____

X		
Signature of Physician or Designee	Date| Time	Printed Name

❑ **Verbal Consent**

Due to the Covid-19 public health recommendations to limit in-person contact with others, the parent or guardian was provided with the information above and verbally consented to the terms of telehealth services. The provider or designee will sign as the witness and document that the consent was given by telephone or video.