Watch Us Grow
PEDIATRICS

TELEHEALTH ACKNOWLEDGEMENT FORM

Patient's Name:_____ Birthdate: _____

1. I understand that my health care provider, Watch Us Grow Pediatrics PC, has recommended to me that I engage in a telehealth appointment with Heather Cadena, MD, Rabia Akbar, MD or Elise Guido CPNP.

2. My health care provider has explained to me how the telehealth technology will be used to connect me with a provider. 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/health care provider visit due to the fact that I will not be in the same room as my health care provider. I understand that the health care provider may use other peripheral devices to assist in the examination.

3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider 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 during the appointment other than my healthcare provider and specialty health care provider 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 examination room; and/or (3) terminate the telehealth appointment at any time.

5. I have had the alternatives to a telehealth appointment explained to me, and in choosing to participate in a telehealth appointment, I understand that some parts of the exam involving physical tests may be conducted at the direction of the primary care provider.

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

7. I understand that billing for the telehealth consultation may occur from 1) the primary care provider and 2) telehealth provider. Billing is at the discretion of the provider. Billing procedures will be explained to me.

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 visit under the terms described herein.

_____ _____

Patient/Guardian signature Date and Time

_____ _____

Witness signature Date and Time