Pediatric Partners
partnering with families
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TELEHEALTH ACKNOWLEDGEMENT FORM

Patient's Name:_____

Date of Birth:_____

I understand that my health care provider, Pediatric Partners, LLC. has recommended to me that I engage in a telehealth appointment with one of their practice providers.
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 video conferencing, video 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 there are potential risks to this technology including interruptions, unauthorized access and technical difficulties. I understand that my healthcare provider or I can discontinue the telehealth appointment if it is felt that the videoconferencing connections are not adequate for this situation. I understand that I can discontinue the telehealth appointment at any time.
I understand that my health care information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the appointment other than my health care provider in order to operate the equipment. The above mentioned people will all maintain confidentiality of any information obtained. I further understand that I will be informed of their presence during the appointment 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 that non-medical personnel leave the room ; and/or (3)terminate the telehealth appointment at any time.
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 by individuals at my location at the direction of the primary care provider.
In an emergency situation, I understand that the responsibility of the telehealth provider may be to direct me to emergency medical services, such as the emergency room. The telehealth provider's responsibility will end upon the termination of the telehealth connection.
I understand that billing is at the discretion of the provider and that the telehealth visit will be billed to my insurance. I further understand that if the claim is denied by my insurance company, I may be billed for the services provided by Pediatric Partners.
I have read this document carefully, and understand the risks and the benefits of the telehealth appointment and have had my questions regarding the visit explained. I hereby consent to participate in a telehealth appointment visit under the terms described herein.

Parent/Guardian Signature:_____

Date:_____

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