Telemedicine at KinderHealth, LLC

Informed Consent Form

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to other entities without my consent.

2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.

3. I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction, and may receive copies of this information for a reasonable fee.

4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time.

5. I understand the benefits and risks of telemedicine and I have discussed any concerns I may have, and my concerns have been addressed to my satisfaction

6. I understand that it is my duty to inform my primary care provider of electronic interactions regarding my care that I may have with other healthcare providers.

7. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

Payment for Telemedicine:
KinderHealth, LLC will bill my insurance for Telemedicine services (or as a self-pay service) as designated in my Payment/Financial agreement. The standard copay and/or deductibles will apply.

Patient Consent To The Use of Telemedicine

I have read and understand the information provided above regarding telemedicine, have discussed it with my primary care provider or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby authorize KinderHealth, LLC to use telemedicine in the course of my diagnosis and treatment.

Patient Name:_____ Date of Birth: _____

_____ _____
Signature of Patient (or person authorized to sign for patient) Date

If authorized signer, relationship to patient: _____