TELEHEALTH ACKNOWLEDGEMENT FORM

Patient's Name:_____ Birthdate: _____

1. I understand that my health care provider, _____, has recommended to me that I engage in a telehealth appointment with _____provider.

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.

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 session may be conducted by individuals at my location at the direction of the specialty health care provider or the primary care provider.

6. I understand that billing for the telehealth consultation may occur from 1) the primary care provider and 2) telehealth provider, and 3) as a facility fee from the site from which I am presented. Billing is at the discretion of the provider. Billing procedures will be explained to me.

7. 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

ADDENDUM IF COACHING SESSION IS BEING VIDEOTAPED:

I am consenting to videotaping of this developmental coaching session and I understand that it may be shared with other pediatric providers as part of a training program on how to perform developmental coaching. No identifying information about me or my child will be shared. The videotape will not be stored on the internet without my further consent. I am free to stop the videotaping of the session at any time or request that all or portions of the videotape not be shared. The videotape will be provided for me to review prior to being shared with participants in the training program if I choose to do so.

Video Consent Addendum:

___ I consent to have the coaching video posted in Dropbox where it can be accessed by a limited group of pediatric providers who are learning to use the TREEHOUSE coaching program

___ I consent to have the coaching video posted on the Maryland Chapter Academy of Pediatrics website for pediatric educational purposes where it can be viewed publicly and may also viewed on You Tube without any identifying information about me or my child

_____ _____

Patient/Guardian signature Date and Time