ADVANCED PEDIATRICS

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TELEHEALTH INFORMED CONSENT

I, _____, hereby consent to participate in telehealth with Advanced Pediatrics. I understand that telehealth is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a patient who are located in two different locations.

Telehealth Requirements & Coverage:

Due to the COVID-19 pandemic, out of state telehealth regulations and insurance coverage for telehealth varies by individual states and policies. By signing this consent form, I agree to the following:

- *I will physically be in the state of Virginia at the time of my telehealth appointment. If I sign on to my telehealth session from another state where my provider is not licensed, I recognize that the appointment will be cancelled, and I will be charged a missed appointment fee of $100.*
- *It is my responsibility to verify my telehealth coverage with my individual insurance plan. If I fail to verify my telehealth coverage and my insurance denies coverage, I recognize that I am 100% responsible for the charges for the appointment.*

I understand the following with respect to telehealth:

- *I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.*
- *I understand that there are risks, benefits, and consequences associated with telehealth, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.*
- *I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions*

are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

- *I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telehealth unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).*
- *I understand that if the patient is having acute symptoms or experiencing a crisis that cannot be resolved remotely, it may be determined that telehealth services are not appropriate, and a higher level of care is required.*
- *I understand that during a telehealth session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call the office at 703-938-5555 to discuss since we may have to re-schedule.*
- *I understand that my provider may need to contact my emergency contact and/or appropriate authorities in case of an emergency.*

I have read the information provided above and discussed it with the office staff. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

_____

Patient Printed Name Date of Birth

_____

Signature of Patient or Parent/Guardian Date