Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. I understand that my health care provider wishes me to engage in a Telehealth visit using Doxy.Me.
2. My health care provider has explained to me how the video conferencing technology will be used to affect such a consultation 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 consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
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 consultation other than my health care provider and consulting health care provider in order to operate the video equipment. The above mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in 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 consultation at any time.
5. I have had the alternatives to a Telehealth consultation explained to me, and in choosing to participate in a Telehealth consultation. I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting health care provider.
6. I understand that billing will occur from Springboro Pediatrics and I may still be responsible for any copays, deductibles or coinsurance applied from my insurance. I also agree to pay for the Telehealth Visit in full if my insurance denies coverage for Telehealth Services.

By signing this form, I certify:

* + That I have read or had this form read and/or had this form explained to me
  + That I fully understand its contents including the risks and benefits of Telehealth.
  + That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

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| Patient’s/parent/guardian signature | Date | Time |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Witness signature | Date | Time |