TELEHEALTH ACKNOWLEDGEMENT FORM

Patient's Name:_____ Birthdate:_____

1. I understand that my Northwest Pediatric Ophthalmology healthcare provider has recommended and scheduled me to engage in a telehealth appointment.
2. My health care provider has explained to me how the telehealth technology will work. Telehealth appointments may be conducted by videoconferencing, video images, still (high quality photo) images, or by telephone conference. I understand 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 the health care provider may use peripheral devices to assist in the examination.
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 video conferencing connections are not adequate for the situation. I understand that I can discontinue the telehealth appointment at any time. I understand that my provider has taken all necessary steps to safeguard my information including using a HIPAA-compliant platform.
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 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 telemedicine 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 exam involving physical tests (additional physical examination, lab tests or radiology imaging) may require an additional appointment or visit to be performed.
6. In an emergency situation, I understand that the responsibility of the telehealth provider may be to direct me emergency medical services, such as an emergency room.
7. I understand that the telehealth appointment will be billed to my insurance, and I may be responsible for all or a portion of the bill depending on my specific insurance provider's coverage. It is my responsibility to check with my insurance carrier to assure this is a covered benefit prior to the telehealth visit.
8. 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.

_____ _____

Printed Name (Guardian if less than 18 yrs old Relationship to Patient

_____ _____

Signature Date & Time