Pediatric Associates of Alexandria

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Patient Name: _____ DOB: _____

1. I understand that my health care provider Pediatric Associates of Alexandria (PAA) wishes me to engage in a telemedicine consultation.
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 telemedicine 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 and consulting health care provider in order to operate the video equipment. The above-mentioned people will all maintain the 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 telemedicine examination room: and or (3) terminate the consultation at any time.
5. I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a telemedicine consultation. I understand that some parts of the exam involving physical tests may be conducted by individuals at my location in the direction of the consulting health care provider.
6. I understand that the billing will occur from both my practitioner (PAA) and be submitted to my insurance. I will be held responsible for any copay and/or deductible associated with my insurance plan.

By e-Signing this form, I certify:

- That I have read or had this form read/or had this form explained to me
- That I fully understand its contents including the risks and benefits of the procedure(s)
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction

_____ _____ _____

Print Patient/Parent/ Guardian | Patient/ Parent/ Guardian Signature | Date