Camelback Pediatrics Telephone/Telemedicine Consent

Email: medicalrecords@camelbackpeds.com Fax: (602) 840-3120

I authorize Camelback Pediatrics to utilize telephone or telemedicine technologies in determining my diagnosis and/or treatment. I understand telemedicine means the practice of healthcare delivery, diagnosis, consultation, treatment and transfer of medical data through interactive audio, video or data communications that occurs in the physical presence of the patient.

Camelback Pediatrics will be consulting _____ through audio, video or data
Patient's Name – PRINTED

imaging and communications.

Benefits

The reason telemedicine is being utilized is for the following reason(s):

- ► Convenience of encounter for the patient.
- ► Access to healthcare technology not physically readily available.
- ► Need for expertise from a consultant not readily available.
- ► Other

Risks

The reasonably foreseeable risks of utilizing telemedicine technologies may include:

- ► Audio or visual images may not be as good as in person.
- ► Telemedicine physician cannot utilize the senses of touch and smell to assist in diagnosis, treatment or therapy.
- ► Other

Alternatives

The possible alternatives may be:

- ► Travel distance to physically see consultant or undergo the testing/procedure.
- ► Undergo therapy available locally which may not produce desired result.
- ► Other

Confidentiality

I understand every reasonable effort will be made to protect the security and confidentiality of my medical information which is copied and forwarded to Camelback Pediatrics either through the mail or transmitted through electronic means as part of telemedicine.

Financial Responsibility

I understand that I am responsible to pay my deductible/coinsurance/copay based on how my insurance processes the claim. If not a covered benefit, I will be responsible for the telemedicine fee of $80.00. (This could happen if your insurance is not regulated by the State of Arizona and falls outside the Executive Order signed by Governor Ducey.) I understand that should I fail to pay, I will be held responsible for my account balance per the signed Financial Policy on file.

Option Not to Participate

I understand I have the option of not participating in telemedicine and can withdraw from participation in utilizing telemedicine technology in my diagnosis or treatment at any time by expressing this to my physician.

Do not sign unless you have read and thoroughly understand this form.

By signing this form, I am stating that I have read, understand, consent and agree to the above. I understand this consent will remain active until I notify Camelback Pediatrics, in writing, of my decision to opt out of my consent for telephone or telemedicine services.

PARENT/LEGAL REPRESENTATIVE SIGNATURE	DATE	TIME (AM|PM)

PHYSICIAN DECLARATION (If necessary to read consent to the patient/parent): I have explained the contents of this document with the patient and have answered all the patient's questions. To the best of my knowledge, the patient/parent has been adequately informed. The patient/parent has consented.

PROVIDER SIGNATURE	DATE	TIME (AM|PM)