TELEMEDICINE ACKNOWLEDGEMENT FORM

Patient's Name:_____ **Birthdate:** _____

1. I understand that Hazel Dell Pediatrics LLC has chosen as a result of the coronavirus pandemic to initiate telemedicine services in the interest of providing ongoing medical care to established patients. This service may or may not continue to be available as the situation regarding the pandemic improves.

2. I understand that telemedicine appointments will be conducted on the HIPAA-compliant doxy.me web-based telemedicine platform and will consist of synchronous and interactive real-time audio and video communication. I understand that this appointment will not be the same as a direct patient/health care provider visit because my child will not be in the same room as my health care provider, and this may result in limitations to the evaluation and treatment my child may receive during a telemedicine visit.

3. I understand that the suitability for a medical concern to be adequately evaluated and managed via a telemedicine appointment will be at the sole discretion of the providers of Hazel Dell Pediatrics LLC. In an emergency situation, I understand that the responsibility of the provider representing Hazel Dell Pediatrics LLC may be to direct me to emergency medical services, such as emergency room, and Hazel Dell Pediatrics LLC is not liable for adverse medical outcomes if I do not pursue the recommended emergency medical evaluation.

4. 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 appointment if it is felt that the videoconferencing connections are not adequate for the situation. I understand that I can discontinue the telemedicine appointment at any time.

5. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes.

6. I understand that charges for the telemedicine visit will be submitted to my insurance provider similar to in-person appointments at the physical site of Hazel Dell Pediatrics LLC at 13250 Hazel Dell Parkway, Suite 103, Carmel IN 46033.

7. I have read this document thoroughly and understand the risks and benefits of telemedicine conducted appointments and have been given the opportunity to ask questions. I hereby consent to participate in telemedicine appointments visit under the terms described herein.

_____ _____

Signature
Parent/Guardian/Patient (if over 18 yrs old)

Date and Time

_____

Parent/Guardian/Patient printed name