Consent for Telehealth Treatment and Services

FOUR CORNERS CHILDREN'S CLINIC
Jessica Rensner, CPNP

To our patients and families: Patients and families are essential participants in healthcare, and we want you to understand your rights and responsibilities while receiving care from us. If you have any questions about this form, please ask your provider. If you are a parent/guardian of a child, please read this agreement with the understanding that "I" and "me" means the child.

Consent for Treatment: I consent to telehealth care performed by my provider and all other associated health care providers at 4 Corners Children's Clinic. This includes all exams, treatment, testing that is diagnostic in nature, and any other service deemed medically necessary by the provider. Due to the remote nature of telehealth I understand the diagnosis and treatment may cause injury or fatality. Additionally I understand that I have the right to refuse healthcare services via telehealth at any time with no effect to my rights to future care or treatment, without prejudice or loss of any benefits that I was otherwise entitled to. If I am pregnant this consent extends to my unborn child.

Consent for Telehealth Services: Telehealth care may involve but is not limited to video, photos, and details of my medical records such as test results and diagnostic images hereafter referred to as *data*. All this data is delivered to my provider by secure electronic form to support the medical services rendered. I will be informed of anyone present in the telehealth encounter and have the right to exclude anyone from the location. As always, all confidentiality protections required by the laws and regulations will be upheld throughout my care. I always maintain the right to stop my participation in telehealth services at any time. I may also request to continue the appointment in person with the understanding that an equivalent in-person service may not be available at the same time, location, or at all. If I decline to receive my healthcare via telehealth this will not affect my future care or treatment, additionally any insurance/program benefits to which I am entitled. If an emergency were to occur during my telehealth visit the provider will manage this emergent situation to the best of their abilities but I should call 911 and remain on the video connection if possible, until help arrives.

Records and Release of Information: All data transmitted during the telehealth visit may become part of my medical record and will not be transferred to anyone outside of my care team except for the reasons listed below or if additional written consent is provided. Just as an in-person visit, I will have access to all the information within my medical record resulting from telehealth services provided by state and federal law. My provider may use/disclose medical information for the purposes of treatment, continuity of care, payment, for internal operations, and when required by law and regulations. All releases of information are subject to the same regulations and laws, as care in person.

Payment Agreement/ Assignment of Benefits: I am responsible for any co-payments, coinsurance, deductibles, or other charges not covered and paid for by insurance or other third-party payors. I authorize 4 Corners Children's Clinic to file any claims for payment of any portion of the patient bills and

assign all rights and benefits payable for health care services to the provider rendering the services. I agree to pay all costs, attorney fees, expenses, delinquent charges, and interest in the event that 4CCC may have to take action to collect because of my failure to pay all incurred charges in full. It is my responsibility to know what providers and telehealth services are covered under my insurance plan. I understand that I may be billed and agree to pay all bills submitted by 4CCC who are providing the telehealth services.

Consent to be Contacted (Telephone Consumer Protection Act): By providing a telephone number (landline or cellular) or other wireless device, I agree that in order for 4CCC as a provision of telehealth services to service my account(s) (including contacting me about appointment reminders, surveys, obtaining potential financial assistance for my account(s)), or to collect any amounts I may owe, 4 Corners Children's Clinic whom are providing my telehealth services may contact me at the telephone number(s) provided which could result in charges to me. I consent that methods of contact may include but is not limited to e-mail, phone calls, including automated technology such as an auto-dialing device, pre-recorded messages, and artificial voice messages as applicable. This consent applies to all services and billing associated with my account(s) and is not a condition of services rendered. By signing this form, I acknowledge that I have read this information and agree to treatment by telehealth.

Patient Printed Name:	Date:
Patient/Guardian Signature:	
Guardian Printed Name:	
Relationship to the Patient:	