PONDEROSA PEDIATRICS

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INFORMED CONSENT TO TELEHEALTH

Telehealth allows Ponderosa Pediatrics to consult, treat and educate using interactive audio, video or data communication regarding my child's treatment. I hereby consent to participating in medical care via telephone or the internet (hereinafter referred to as Telehealth) with the clinician listed below:

Patient's Name: _____ Clinician: Lari Frazee, D.O. with Ponderosa Pediatrics

I understand I have the following rights under this agreement:

I have a right to confidentiality with Telehealth under the same laws that protect the confidentiality of my medical information for in-person health concerns. Any information disclosed by me during the course of my treatment, therefore, is generally confidential.
There are, by law, exceptions to confidentiality, including mandatory reporting of child, adult abuse, and any threats of violence I may make towards a reasonably identifiable person. I also understand that if I am in such mental or emotional condition to be a danger to myself or others, my healthcare provider has the right to break confidentiality to prevent the threatened danger. Further, I understand that the dissemination of any personally identifiable images or information from the Telehealth interaction to any other entities shall not occur without my written consent.

I understand there is no guarantee that all treatment of all clients will be effective. Thus, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.

I further understand that there are risks unique and specific to Telehealth, including but not limited to, the possibility that our session or other communication by my healthcare provider to others regarding my treatment could be disrupted or distorted by technical failures or could be interrupted or could be accessed by unauthorized persons. In addition, I understand that Telehealth treatment is different from in-person healthcare services and that if my healthcare provider believes I would be better served by another form of healthcare service, such as in-person treatment, I will be referred to seek an in-person appointment in my geographic area that can provide such services.

I have read and understand the information provided above. I have the right to discuss any of this information with my healthcare provider and to have any questions I may have regarding my treatment answered to my satisfaction.
I understand that I can withdraw my consent to Telehealth communications by providing written notification to Ponderosa Pediatrics. My signature below indicates that I have read this Agreement and agree to its terms.

_____ _____
Patient Name Date

_____
Guardian Signature

_____
If signed by legal representative, relationship to patient