PONDEROSA PEDIATRICS

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# Telehealth Informed Consent

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 Telehealth.

Patient's Name: _____ DOB:_____

Clinician's Name: Lari L. 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 my treatment, therefore is generally confidential. There are, by law, exceptions to confidentiality; including mandatory reporting of child abuse, and any threats of violence made towards a reasonably identified person. I also understand that if I am in such a 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.
- I understand that dissemination of any personally identified images or information from the Telehealth interaction to any other entities shall not occur without my written consent.
- I understand that 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.
- Furthermore, I 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, could be interrupted, or accessed by unauthorized persons.
- I understand that Telehealth treatment is different from in-person treatment 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.

I have read and understand the information provided to me above. I have the right to discuss any of this information with my healthcare provider and have any questions I 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.

_____ _____
Parent/Legally Authorized Representative (Print) Date

_____ _____
Signature Relationship to Patient