FIREFLY PEDIATRICS

# Informed Consent for Telemedicine/Telehealth

1. I understand that my child's health care provider will be providing telemedicine/telehealth visits to me/my child/children.
2. I authorize and voluntarily consent to receive these telemedicine/telehealth visits and understand that it is for the purpose of providing basic healthcare and that this telemedicine/telehealth visit may be performed by an M.D., D.O., or CPNP. I further acknowledge that I may speak with a licensed or registered nurse for the purpose of gathering further information so that my provider may make an informed decision regarding my child's health care.
3. I understand that the telemedicine/telehealth visit will be conducted using video conferencing technology. The visit will not be the same as an in-person visit because my child and I will not be in the same room as the health care provider.
4. I understand that there are potential risks to utilizing telemedicine/telehealth. Some of these risks include, and are not limited to, disruptions due to poor connections or overworked networks, technical difficulties such as malfunctioning cameras or microphones, and privacy/security risks such as unauthorized access due to hacking or other cyber-attacks. I understand that either the provider or I can discontinue the telemedicine/telehealth visit if it is felt that the videoconferencing connections are not adequate for this situation.
5. I understand that not all conditions and visits are appropriate for telemedicine/telehealth. My provider will tell me when he/she does not believe a visit is appropriate to be conducted on this platform. I have the ability to decline a telemedicine/telehealth visit and request an in-person visit for any reason.
6. I understand that Firefly Pediatrics will act in accordance with all applicable federal and state laws as they relate to telemedicine/telehealth.
7. The HIPAA compliant platforms Firefly Pediatrics uses are Doxy.Me and Zoom. In case of one or more platform failures, I may be offered a non-HIPAA compliant platform and I can choose to accept or not for that visit.
8. I further understand that not all insurance companies pay for telemedicine/telehealth and that I may incur some financial responsibility, including copays or coinsurances. I agree to pay the costs not covered by my insurance company.
9. I hereby provide my consent to telemedicine/telehealth treatment, and I understand I may revoke it at any time.

Please list all minor children for whom you are legally entitled to make this agreement:

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_____ _____

Signature of Parent or Legal Guardian Date

_____ _____

Printed name of Parent or Legal Guardian Relationship