Mountain View Pediatrics
77 West Forest Avenue, Suite 304
Flagstaff, AZ 86001
(928) 214-3600

Patient Name: _____
Date of Birth: _____
Parent/Guardian Name: _____

General Consent for Telehealth Consultation

For the purposes of Mountain View Pediatrics (MVP), Telehealth is defined as a visit that occurs through a synchronous telecommunications system (a live internet-based platform) with the patient located outside of the MVP office and the provider speaking with the parent or legal guardian while observing the patient through the video and audio platform.

I understand the following:

1. The purpose of a telehealth consult is to assess and treat a medical condition.
2. The telehealth consult is done through a two-way video and audio platform whereby the physician or other healthcare provider at MVP can see my image on the screen and hear my voice. However, unlike a traditional medical consult, the physician or other health provider does not have the use of the other senses such as touch or smell; and it may not be equal to a face-to-face visit.
3. Since the telehealth consultation is virtual and not face-to-face, the healthcare provider must rely on information provided by me as the parent or legal guardian. MVP and its healthcare providers cannot be responsible for advice, recommendations and/or decisions based on incomplete or inaccurate information provided by me or others.
4. There may be potential risks with the use of this technology. These include but are not limited to:
    - Interruption of the audio/video link.
    - Disconnection of the audio/video link
    - A picture that is not clear enough to meet the needs of the consultation
    - Electronic tampering.

    If any of these risks occur, the consultation might need to be stopped.
5. The laws that protect privacy and the confidentiality of medical information including HIPPA also apply to telehealth.
6. All medical reports resulting from a telehealth consultation are part of a patient's medical record.
7. I will be responsible for any copayments, coinsurances or deductibles that apply to my telehealth visit.
8. I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without effecting my right to future care or treatment.
9. By signing this form, I am consenting to receive healthcare services via telehealth.

_____
Patient's Name

_____
Print Name of Parent or Legal Guardian

_____ _____
Parent or Guardian Signature **Date**