PEDIATRIC ASSOCIATES MEDICAL GROUP, INC.

PRACTICE LIMITED TO INFANTS, CHILDREN, AND ADOLESCENTS

INFORMED CONSENT FOR TELEMEDICINE SERVICES

Telemedicine involves the use of electronic communications to enable health care providers to deliver services to a patient when he/she is at a different site than the provider. The information may be used for diagnosis, therapy, follow-up and/or education. It includes a variety of applications and services using two-way images, video, audio, and/or other forms of telecommunication technology. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data, to safeguard the data, and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

- Efficient and convenient medical evaluation and management
- Improved access to healthcare
- Facilitates earlier diagnoses
- Increases timeliness of treatment
- Reduces healthcare costs (including travel and ER visits)
- Reduces time away from work and school

Possible Risks (include, but not limited to):

- Transmission of medical information could be interrupted or distorted during the consultation due to technical difficulties
- Video and/or any information may not be transmitted clearly to render an accurate diagnosis
- Insufficient information to allow for appropriate medical decision making by the physician
- Lack of access to medical records may result in adverse reactions or other judgment error (lack of knowledge of past medical history, allergies, etc.)
- Provider may recommend alternative care including follow-up visit, urgent care, or emergency facility
- Not every medical condition can be evaluated accurately using telemedicine which may cause a delay in diagnosis and affect outcome
- Escalating medical conditions should be evaluated by direct contact with a provider
- Security protocols could fail, causing a breach of privacy of personal medical information

I consent to using telemedicine services and understand the following:

1. I understand that the HIPAA laws that protect the privacy and confidentiality of patient information apply to telemedicine services
2. I understand that a limited physical examination will occur during the telemedicine consultation which may affect diagnosis
3. I elected to a telemedicine consultation in lieu of a direct consultation by a healthcare provider
4. I understand that I will be responsible for all payment of all co-payments, co-insurance, deductibles, and non-covered services

I, the undersigned, have read this Informed Consent for Telemedicine Services and understand the risks and benefits.

_____	_____
Name	Date
_____	_____
Signature	Patient's Name
_____	_____
Relationship to Patient	Patient's Date of Birth

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