Wildflower Pediatrics, PA
11609 Anderson Mill Road
Austin, Texas 78750

CONSENT TO PARTICIPATE IN A TELEMEDICINE APPOINTMENT

1. I understand that my health care provider wishes me to engage in a telemedicine consultation using Doxy.me.
2. My health care provider has explained to me how the Doxy.me video conferencing technology will be used to affect such a consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.
3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my healthcare provider or I can discontinue the telemedicine consult/visit if it is felt that the Doxy.me videoconferencing connections are not adequate for the situation.
4. I understand that if others are present during the consultation other than my health care provider, they will maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room: and or (3) terminate the consultation at any time.
5. I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a Doxy.me telemedicine consultation.
6. In an emergency, I understand that the responsibility of the telemedicine consulting specialist is to advise my local practitioner and that the specialist's responsibility will conclude upon the termination of the Doxy.me video conference connection.
7. I have had a direct conversation with my healthcare provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand
8. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
9. I understand that my insurance carrier will have access to my medical records for quality review/audit.
10. I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit.
11. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.
12. I understand that this document will become a part of my medical record.

BY SIGNING THIS FORM, I CERTIFY:

- That I have read or had this form read and/or had this form explained to me
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

_____ _____

Patient/Parent/Guardian Printed Name Patient/Parent/Guardian Signature

Date: _____