WESTCHESTER PEDIATRICS, LLC
Telehealth Informed Consent

Telehealth involves the use of secure electronic communications, information technology, or other means to enable a healthcare provider at one location, and a patient in another location to share individual patient clinical information for the purpose of consulting with, diagnosing, treating, prescribing, and/or referring the patient to in-person care, as determined clinically appropriate. This "**Telehealth Informed Consent**" informs the patient ("**patient,**" "**you,**" or "**your**") concerning the treatment methods, risks, and limitations of using a telehealth platform.

Services Provided:

Telehealth services offered by Westchester Pediatrics, LLC ("**Practice**"), and the Practice's engaged providers ("**Providers**") may include a patient consultation, diagnosis, treatment recommendation, prescription, and/or a referral to in-person care, as determined clinically appropriate (the "**Services**"). Your Provider will be licensed in the state where you are located at the time of your consultation, or otherwise meet a professional licensure exception under applicable state law.

Electronic Transmissions:

The types of electronic transmissions that may occur using the telehealth platform include, but are not limited to:

- Completion of medical intake forms;
- Exchange and review of patient medical intake forms, patient health records, images, diagnostic and/or lab test results
- Two-way interactive audio-video interaction between you and your Provider;
- Other electronic transmissions for the purpose of rendering clinical care to you.

Expected Benefits:

- Improved access to care by enabling you to remain in your preferred location while your Provider consults with you. Our telehealth services are available **during office hours**
- Easy access for follow-up care. If you need to receive non-emergent follow-up care related to your treatment, please contact your Provider by **calling the office at 305 273-1200**.

Service Limitations:

- The primary difference between telehealth and direct in-person service delivery is the inability to have direct, physical contact with the patient. Accordingly, some clinical needs may not be appropriate for a telehealth visit and your Provider will make that determination.
- **OUR PROVIDERS DO NOT ADDRESS MEDICAL EMERGENCIES. IF YOU BELIEVE YOU ARE EXPERIENCING A MEDICAL EMERGENCY, YOU SHOULD DIAL 9-1-1 AND/OR GO TO THE NEAREST EMERGENCY ROOM. AFTER RECEIVING EMERGENCY HEALTHCARE TREATMENT, YOU SHOULD CALL THE OFFICE FOR A FOLLOW UP APPPOINTMENT.**
- If it is determined during the initial screening of the telehealth visit that you should be seen in person, either in your Provider's office or in a recommended facility, you **will not** be charged for the telehealth visit. Appropriate emergency questions will be asked at the beginning of the telehealth visit that will determine what will be the best place for you to receive care.

Security Measures:

The electronic communication systems we use will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption. All the Services delivered to the patient through telehealth will be delivered over a secure connection that complies with the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Possible Risks:

- Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment and technologies, or provider availability.
- In the event of an inability to communicate as a result of a technological or equipment failure, please contact the Practice at 305 273 1200.
- The quality of transmitted data may affect the quality of services provided by your Provider. Changes in the environment and test conditions

could be impossible to make during delivery of telehealth services.
- In rare events, your Provider may determine that the transmitted information is of inadequate quality, thus necessitating a rescheduled telehealth consult or an in-person office visit.
- In very rare events, security protocols could fail, causing a breach of privacy of personal medical information.

Patient Acknowledgments:

By checking the box associated with "Telehealth Informed Consent," you acknowledge that you understand and agree to the contents above and further agree with the following:

1. I understand that if I am experiencing a medical emergency, that I will be directed to dial 9-1-1 immediately and that our Providers are not able to connect me directly to any local emergency services.

2. I understand there is a risk of technical failures during the telehealth encounter beyond the control of the Practice. I agree to hold harmless the Practice for delays in evaluation or for information lost due to such technical failures.

3. I understand that 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 affecting my right to future care or treatment. I understand that I may suspend or terminate use of the telehealth services at any time for any reason or for no reason.

4. I understand that alternatives to telehealth consultation, such as in-person services are available to me.
5. I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.

6. I understand that it is necessary to provide a complete and accurate medical history and will update my medical health records periodically, but no less than once a year.

7. I understand persons may be present during the consultation other than my Provider in order to operate the telehealth technologies. I further understand that I will be informed of their presence in the consultation, and their role, and thus will have the right to request the following: (1) omit specific details of my medical history/examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telehealth examination; and/or (3) terminate the consultation at any time.

8. I understand I have the right to object to the videotaping of the telehealth consultation.

9. Our Providers reserve the right to deny care for potential misuse of the Services or for any other reason if, in the professional judgment of our Providers, the provision of the Service is not medically or ethically appropriate.

10. I understand that I will not be prescribed any narcotics for pain, nor is there any guarantee that I will be given a prescription at all.

11. I understand that federal and state law requires health care providers to protect the privacy and the security of health information. I understand that Practice will take steps to make sure my health information is not seen by anyone who should not see it.

12. I understand that if I participate in a consultation, that I have the right to request a copy of my medical records and/or consultation report, which will be provided to me at reasonable cost of preparation, shipping and delivery.

13. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes.

14. I understand that I may not be covered under my current health insurance plan for telehealth services.

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Patient Informed Consent

I have carefully read this form and fully understand its contents, including the risks and benefits of the telehealth services. I hereby give my informed consent to participate in a telehealth consultation under the terms described herein. By checking the box associated with "Telehealth Informed Consent", I acknowledge that I understand and agree with the above and hereby consent to receive Practice's telehealth services:

□ ACCEPT. By checking the Box for this **"TELEHEALTH INFORMED CONSENT"** I hereby state that I have read, understood, and agree to the terms of this document.

PATIENT'S NAME:

_____

PATIENT'S DATE OF BIRTH:

_____

PATIENT'S SIGNATURE:

_____

DATE:

_____

If signing on behalf of a minor:

PARENT/LEGAL GUARDIAN'S NAME:

_____

PARENT/LEGAL GUARDIAN'S SIGNATURE:

_____

DATE:

_____