TELEHEALTH INFORMED CONSENT
Cumberland Pediatrics, Marietta, GA

Telehealth is healthcare provided by any means other than a face-to-face visit. In telehealth services, medical and mental health information is used for diagnosis, consultation, treatment, therapy, follow-up, and education. Health information is exchanged interactively from one site to another through electronic communications. Telephone consultation, videoconferencing, transmission of still images, e-health technologies, patient portals, and remote patient monitoring are all considered telehealth services.

Check off that you have given the patient this information and that they have responded with a **YES**

_____ I understand that telehealth involves the communication of my medical/mental health information in an electronic or technology-assisted format.

_____I understand that I may opt out of the telehealth visit at any time. This will not change my ability to receive future care at this office.

_____I understand that telehealth services can only be provided to patients, including myself, who are residing in the state of Georgia at the time of this service.

_____I understand that telehealth billing information is collected in the same manner as a regular office visit. My financial responsibility will be determined individually and governed by my insurance carrier(s), Medicare, or Medicaid, and it is my responsibility to check with my insurance plan to determine coverage.

_____I understand that all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include but are not limited to:

It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures. Electronic systems that are accessed by employers, friends, or others are note secure and should be avoided. It is important for me to use a secure network. Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures.

_____I agree that information exchanged during my telehealth visit will be maintained by the doctors, other healthcare providers, and healthcare facilities involved in my care.

_____I understand that medical information, including medical records, are governed by federal and state laws that apply to telehealth. This includes my right to access my own medical records (and copies of medical records).

_____I understand that Skype, FaceTime, or a similar service may not provide a secure HIPAA-compliant platform, but I willingly and knowingly wish to proceed.

Witness to Patient Acknowledgement _____
Date:_____