LINCOLN PEDIATRIC GROUP

Telehealth Consent

I, (Patient, parent or Guardian) _____, agree to receive medically necessary live, interactive video telehealth services for (patient name), _____ patient Date of Birth _____from a provider, who is located at a distant site location, for Lincoln Pediatric Group.
This distant site location is located at 4501 S. 70th Suite 110, Lincoln, NE 68516. Phone: (402)489-3834

I, (patient, parent or Guardian) _____, understand that:

a. I retain the right to refuse telehealth consultation at any time without affecting my right to future care or treatment and without risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
b. All Existing confidentiality protections shall apply to my telehealth consultation.
c. I shall have access to all medical information resulting from the telehealth consultation, as provided by law.
d. Information from the telehealth service (images that can be identified as mine or other medical information from the telehealth service) cannot be released to researchers or anyone else without my written consent.
e. If I decline telehealth services, other alternative options are available to me, including in person services.
f. I will be informed whether the telehealth consultation will be or will not be recorded.
g. I will be informed of all people who will be present at all sites during my telehealth service.
h. I retain the right to exclude anyone form either the originating or distant site.
i. I understand that this consent is valid for 1 year for any telehealth services with this health care provider.
j. I understand a claim for this service will be submitted to my insurance as an office visit, and that I am responsible for any copay or deductible balance.

I have read this document carefully and my questions have been answered to my satisfaction.

Signature of Patient/Parent or Guardian: _____Date: _____