Please reply the following if you would like to use the Telemedicine services:

“I (parents name)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_acknowledge and agree with the below telemedicine waiver for my child (your child’s name)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Child’s Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_ “

TRUMBULL PEDIATRICS TELEHEALTH ACKNOWLEDGEMENT FORM

1. I understand that my health care provider, Trumbull Pediatrics, has recommended to me that I engage in a telehealth appointment with a Trumbull Pediatrics provider due to the symptoms or exposure that my child or I have.

2. I understand the telehealth visit will by via video/virtual conference through Doxy.me. I understand that this appointment 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 to provide me with a physical exam.

3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telehealth appointment if it is felt that the videoconferencing connections are not adequate for the situation. I understand that I can discontinue the telehealth appointment at any time

4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the appointment other than my healthcare provider in order to operate the equipment such as a Trumbull Pediatric employee. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence during 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 personnel to leave the telehealth examination room; and/or (3) terminate the telehealth appointment at any time.

5. In an emergency, I understand that the responsibility of the telehealth provider may be to direct me to emergency medical services, such as emergency room. Or the telehealth provider may determine I need to come into the office and be examined by a Trumbull Pediatrics provider. The telehealth provider’s responsibility will end upon the termination of the telehealth connection.

6. I understand that billing for the telehealth consultation will be billed by Trumbull Pediatrics. I understand that these services may not be covered under my insurance plan and agree to pay for these services. Fees will range based on my insurance plan benefits or type of visit provided (length of visit and complexity determined by the physician).

7. I have read this document carefully and understand the risks and benefits of the telehealth appointment. I hereby consent to participate in a telehealth appointment visit under the terms described herein.

Your email acknowledgement will be attached to this waiver and placed in your chart as your acceptance to these terms.

Once this is received with the parent's consent we will send you the time, doctor's name and VERY SIMPLE INSTRUCTIONS to get on Doxy.Me.

The doctor can also prescribe medication if medically necessary during the visit. We hope this information is helpful to all of you.

Remember please call at any time at 203-268-1766