Premier Pediatrics, P.A.
8675 College Boulevard, Suite 100
Overland Park, KS 66210
913-345-9400
913-345-9408 fax

PREMIER
Pediatrics

Tele-Health Consent

By signing this agreement, I understand that a medical exam and treatment will be provided through an interactive video connection. Electronic systems used will incorporate network and security protocols to protect the confidentiality of patient identification. No recording of the visit will be done but the visit will be documented in the medical record in the same manner in which all visits are documented in the record.

I understand there are potential risks to this technology, including:
1. The video connection may not work or that it may stop working during the consultation.
2. The video picture or information transmitted may not be clear enough to be useful for the consultation.
3. It may be necessary to be seen at Premier Pediatrics or an after-hours facility if the information available by audio and video is not felt to be sufficient.

The benefits of a tele-health consultation include that travel to the consult location may not be required, allowing a more convenient and expedited visit with the healthcare provider.

By signing below, I understand:
1. That a limited physical exam will take place during the videoconference.
2. That I have the right to ask my healthcare provider to discontinue the conference at any time.
3. The current procedure for tele-health visits as described on www.premierforkids.com/videovisit and agree to test my personal computer, tablet, or smart phone prior to the visit to be sure the platform works. (If it does not, instructions are available on our website.)

I authorize the release of any relevant medical information from this visit to third party payers and other healthcare providers who may need this information for continuing care purposes. I hereby release Premier Pediatrics, its personnel and any other person participating in my care from any and all liability which may arise from the use of video conferencing technology.

I have read this document and understand the risk and benefits of the tele-health consultation and have my questions regarding the procedure explained and I hereby consent to participate in a tele-health visit, under the conditions described in this document.

Date: _____

Patient's Name: _____Date of Birth_____

Patient's Name: _____Date of Birth_____

Patient's Name: _____Date of Birth_____

Patient's Name: _____Date of Birth_____

Patient's Name: _____Date of Birth_____

Responsible Party Printed Name: Responsible Party Printed Signature:

_____ _____