



Virag Pandeya, MD



## CONSENT FOR SCHOOL BASED TELEHEALTH CONSULTATION AGREEMENT FOR TREATMENT

I request and consent to having my child \_\_\_\_\_ examined and evaluated by medical providers affiliated with Graves Gilbert Clinic by means of interactive/video. This telemedicine consultation may be used to help diagnose, manage, or treat my child.

In addition, I understand and agree to the following:

- The consulting health care provider or specialist *will be* at a different location from my child. The school nurse or other qualified practitioners will be present with the child in the room to assist in the examination and evaluation. I may attend electronically or in person as well if I provide information allowing me to be reached in a timely manner.
- Additional technical personnel may be present during the consultation as needed to operate the telemedicine equipment.
- This telemedicine consultation program is not replacement for my child's primary or specialty care, and is being provided to enhance the school based health service
- The results of the examination will become a part of the child's medical record, which could include video and/or audio recording of the session as deemed appropriate by the consulting provider or specialist. The consulting provider or specialist will send the results of the teleconferenced visit to your child's primary care provider.
- The consulting provider or specialist may recommend additional tests and treatment, and it is my responsibility to follow-up on such recommendations.
- Although the equipment and resources are designed to protect patient confidentiality and to provide accurate and timely transmissions, the risk remains for technical difficulties, interruptions, and unauthorized access.
- Your child's school and Graves Gilbert Clinic will attempt to reach you before the telemedicine visit takes place, however, in the event we are unable to contact you, you give your permission for the telemedicine visit to take place, and Graves Gilbert Clinic will send you a summary of the visit and recommendations that were made.
- Telehealth consultations may be billed to my insurance when appropriate. I authorize direct payment to the clinic the benefits provided under any health care plan or medical expensed policy due to me or payable by the plan. I further authorize the clinic to release any information required by any third party payer regarding any claim for payment.

Please indicate whether you want to be notified of a telemedicine visit before it happens.

\_\_\_\_ YES    \_\_\_\_ NO    Contact Number: \_\_\_\_\_

I have received a copy of Graves Gilbert Clinic's Notice of Privacy Practices.

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent/Legal Guardian Printed Name: \_\_\_\_\_

Parent/Legal Guardian Signature: \_\_\_\_\_

Relation: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_