Meridian Pediatrics

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TELEMEDICINE ACKNOWLEDGMENT FORM

1. I UNDERSTAND THAT MY HEALTH CARE PROVIDER HAS RECOMMENDED TO ME THAT I ENGAGE IN A TELEMEDICINE APPOINTMENT.

2. MY HEALTH CARE PROVIDER HAS EXPLAINED TO ME HOW THE TELEMEDICINE TECHNOLOGY WILL BE USED TO CONNECT ME WITH MY PROVIDER.

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 TELEMEDICINE APPOINTMENT IF IT IS FELT THAT THE VIDEOCONFERENCING CONNECTIONS ARE NOT ADEQUATE FOR THE SITUATION. I UNDERSTAND THAT I CAN DISCONTINUE THE TELEMEDICINE APPOINTMENT AT ANY TIME. I RECOGNIZE THAT THIS DOES NOT SUBSTITUTE FOR FACE-TO-FACE EVALUATION.

4. IN AN EMERGENCY SITUATION, I UNDERSTAND THAT THE RESPONSIBILITY OF MY PROVIDER MAY BE TO DIRECT ME TO EMERGENCY MEDICAL SERVICES, SUCH AS EMERGENCY ROOM. MY PROVIDER'S RESPONSIBILITY WILL END UPON THE TERMINATION OF THE TELEMEDICINE CONNECTION.

5. I UNDERSTAND THAT MY HEALTH CARE PROVIDER WILL SUBMIT THIS TELEMEDICINE APPOINTMENT TO MY INSURANCE COMPANY. I UNDERSTAND THAT I WILL BE RESPONSIBLE FOR ANY FEES DEEMED TO BE THE PATIENT'S RESPONSIBILITY (INCLUDING COPAYS, DEDUCTIBLES, CO-INSURANCE CHARGES, AND NON-COVERED SERVICES).

6. I UNDERSTAND THAT MY HEALTH CARE PROVIDER WILL CHARGE A $25.00 CONVENIENCE FEE FOR MY TELEMEDICINE APPOINTMENT IN ADDITION TO ANY VISIT CHARGES. THIS CONVENIENCE FEE IS NOT BILLABLE TO INSURANCE.

PATIENT NAME _____

PRIMARY CARE PHYSICIAN _____

PARENT/GUARDIAN SIGNATURE _____

DATE/TIME _____

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www.meridianpediatrics.net