Emerald Coast Pediatric Sleep Consultants, LLC

Office Use Only
Patient ID#:

Informed Consent for Telemedicine Services

Patient Name: _____

Date of Birth: _____

Location of Patient (address): _____

_____

Today's Date: _____

Provider Name: **Sonia A. Smith MN, ARNP**

Provider Location: **400 Gulf Breeze Pkwy, Suite 204 Gulf Breeze, FL 32561**

1. I understand that my health care provider Sonia Smith, MN, ARNP wishes me to engage in a telemedicine consultation.

2. My health care provider has explained to me how the video conferencing technology will be used to affect such a consultation. I understand that this consultation 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.

3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider(s) or myself can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

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 consultation other than my

health care provider and consulting health care provider in order to operate the video equipment. The above mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in 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 non-medical personnel to leave the telemedicine examination room; and/or (3) terminate the consultation at any time.

5. I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a telemedicine consultation, I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting health care provider.

6. In an emergent consultation, I understand that the responsibility of the telemedicine consulting specialist is to advise my local practitioner and that the specialist's responsibility will conclude upon the termination of the video conference connection.

7. I understand that billing will occur from both my practitioner and as a facility fee from the site from which I am presented.

8. I have read this document carefully, and understand the risks and benefits of the teleconferencing consultation and have had my questions regarding the procedure explained and I hereby consent to participate in a telemedicine visit under the terms described herein.

Patient's/parent/guardian signature: _____

Date: _____

Time: _____