



FOR PPT USE ONLY

MRN Number

Telehealth Patient Consent Form

PATIENT NAME: _____

DATE OF BIRTH: _____

MEDICAID NUMBER: _____

- PURPOSE:** The purpose of this form is to obtain your consent to participate in a telemedicine/telehealth services in connection with the following procedure/treatments/and /or services.
- NATURE OF TELEHEALTH/TELETHERAPY:** Your child's tele session will be with a Premier Pediatric Therapy health professional clinician through the use of interactive online telemedicine resources.
 - Details of medical history, medical records, treatment, goals, and outcome will be discussed via tele session with clinician.
- MEDICAL INFORMATION AND RECORDS:** All existing laws regarding your access to medical information and copies of your records can be assessed in the same manor according to the Patient Rights of PPT. Medical Information could be shared with the Secure HIPAA regulated Telehealth software in order to complete healthcare session.
- CONFIDENTIALITY:** Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the tele session appointment, and all existing confidentiality protections under federal and Texas State law apply to information disclosed during this tele session appointment.
- RIGHTS:** You may withhold or withdraw consent to the tele session appointments at any time without affecting your right to future care or treatment, or rising the loss or withdrawal of any program benefits to which you would otherwise be entitled
- DISPUTES:** You agree that any dispute arriving from the telemedicine consult will be resolved in the State of Texas, and that Texas state laws shall apply to all disputes.
- RISK, CONSEQUENCES AND BENEFITS:** You have been advised of all the potential risk. Consequences and benefits of telemedicine. Your health care practitioner has discussed with you the information provided above. You have had the opportunity to ask questions about the information presented on this form and the telemedicine consultation. All your question have been answered, and you understand the written information provided above.

I, _____, agree to participate in Tele Sessions with Premier Pediatric Therapy as described above.

Caregiver Signature: _____ Date: _____