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PEDIATRIC CARE OF ROCKVILLE, P.A.

Kathleen M. Hawkins, MD
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CONSENT TO PARTICIPATE IN A TELEMEDICINE CONSULTATION

1. I _____ (name of legal guardian/ or patient if 18 years or older) authorize and voluntarily consent to the participation and treatment of _____ (name and DOB of patient) in a Telemedicine Consultation with a provider at Pediatric Care of Rockville.

2. I understand that as a participating patient/guardian, I will communicate by interactive telehealth with a pediatrician or pediatric nurse practitioner from Pediatric Care of Rockville. The telehealth visit will take place through an electronic medical record platform that is compliant with the Health Insurance Portability and Accountability Act (HIPAA).

3. It has been explained to me how the telehealth technology will be used to conduct a visit. I understand that this visit will not be the same as an in-person visit due to the fact that a patient and provider are not in the exam room. I understand that treatment may not be feasible via telehealth and the result of the visit may be a recommendation to have an in-person visit. I also understand that I have the option to see a provider in person rather than via telehealth.

4. By agreeing to this consent, I authorize Pediatric Care of Rockville to release information to my insurance company in relation to billing for this visit. I understand that telemedicine visits are billed in the same way as visits in the office. These billing procedures are outlined in the Financial Policy.

5. I understand that I have the right to withdraw my consent at any time.

I have read this document carefully, and hereby consent to participate in the Telemedicine consultation/services under the terms described above.

_____ _____

Signature of guardian/patient (if over 18 years) Relationship to patient if other than self

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