Windhaven Adolescent & Sports Medicine

SPECIALIZED HEALTHCARE FOR TEENS & TWENTIES

WINDHAVEN ADOLESCENT & SPORTS MEDICINE INFORMED CONSENT FOR **TELEMEDICINE**

Patient's Name (First and Last): _____ Patient's Date of Birth: _____

Name of Parent or Guardian if patient is under 18 y/o: _____ DATE: _____

PLEASE READ AND SIGN BELOW

1. WHAT IS A TELEMEDICINE VISIT: telemedicine is a remote electronic video conference between the physician and the patient. It may include electronic prescribing, sharing of educational material, and the provision of letters or referrals. We use an electronic software which protects the confidentiality of the patient and their identifying information.

2. WHEN IS TELEMEDICINE NEEDED: a telemedicine visit might be requested in the event the patient is away from home at camp, school, or work. Occasionally telemedicine may be preferred if the patient needs to be seen quickly or can't travel to the clinic. Additionally, this type of visit provides a cost savings.

3. HOW SHOULD THE PATIENT/FAMILY PREPARE: please see our website **www.windhaventeens.com** or **www.healthyounghumans.com** and click on "How to Telemedicine."

4. WHAT ARE MY RIGHTS CONCERNING TELEMEDICINE VISITS? You have the right to refuse to participate or to stop participating in a telemedicine visit at any time. This refusal will not affect your right to future care or treatment. You should know that the laws that protect privacy and confidentiality of health care information apply to telemedicine services. Your health information may be shared for the purposes of billing and scheduling. You should know that the telemedicine visit is documented in chart and part of your medical record just like the in-office visit is. You have access to view this record by requesting it or through the MyChart patient portal.

By signing this form, I attest that I/my child or ward (if patient is under 18) (1) have personally read this form or had it explained to me and fully understand and agree to it's contents; (2) have had any questions answered to my satisfaction and I understand the risks, benefits, and alternatives to telemedicine; and (3) I/my child or ward (if patient is under 18) will be located in the state of Texas at the time of my telemedicine visit(s).

_____

Name printed **AND** signed (if patient is under 18, parent/gaurdian should print *their* name and sign)

_____ (Date)

Laura H. Scalfano, M.D. – Board Certified in Pediatrics

972.473.TEEN (8336) – **windhaventeens.com**

17051 N Dallas Parkway Suite 300

Addison, TX 75001-7109