PEDIATRIC TELEHEALTH INFORMED CONSENT

To our patients and families: Thank you for choosing us for your telehealth care. Telehealth involves a two-way, real- time interactive communication between a patient and a physician or practitioner at a distant site through video communications equipment that includes, at a minimum, audio and visual equipment.

Consent to Telehealth Treatment: I consent to telehealth performed by my physician, psychologist and/or other associated health care providers ("Providers") at National Jewish Health ("NJH") as part of my medical and/or behavioral health treatment. I understand that telehealth may include evaluation, assessment, consultation, treatment planning, and therapy. Telehealth will occur through a HIPAA-compliant audio/video communications service.

I understand I have the following rights with respect to telehealth:

1. I have the right to withhold or remove consent for telehealth at any time without affecting my right to future care or treatment, nor endangering the loss or withdrawal of any program benefits to which I would otherwise be eligible.

2. I have the right to refuse or stop participation in telehealth services at any time and request alternate services, such as an in-person appointment. However, I understand that equivalent in-person services might not be available at the same time or date as telehealth services.

3. All confidentiality laws and regulations that protect my personal information also apply to telehealth. I understand that my telehealth visit could be disrupted or distorted by technical failures despite reasonable efforts on the part of my Providers and NJH.

4. I understand that telehealth may not be the same as in-person services. I understand that if my Providers believe I would be bettered served by other services (e.g., in-person visit or therapy), I may be referred to a health professional in my area who can provide such services, as applicable.

5. I understand that the practice of medicine is not an exact science and that diagnosis and treatment may involve risks of injury or even death. I acknowledge that no guarantees have been made to me as to the results of examination or treatment at National Jewish Health.

6. **I understand that NJH's telehealth service does NOT provide emergency services. If I am experiencing an emergency situation, including but not limited to thoughts of hurting myself or others, a medical emergency, or are in an unsafe situation, I should call 911, proceed to the nearest hospital emergency room, or call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255) for free 24-hour hotline assistance. If an emergency situation occurs during a telehealth encounter, I should access the resources listed above and stay on the video connection (if applicable) until help arrives.**

7. I understand that I am responsible for (1) providing internet access and a personal device with audio/visual capabilities (e.g., computer, tablet, and/or phone with web camera and microphone) for the telehealth session, (2) the information security on my computer, and (3) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions during my telehealth session. I understand that it is not permissible to record my telehealth sessions using audio and/or visual means without approval from my Providers.

8. Financial Agreement/Third Party Assignment: I am responsible for full payment of all National Jewish Health bills, and I must pay amounts within a time period National Jewish Health deems reasonable. Please refer to your most recent executed copy of the National Health Jewish Consent to Treatment documents.

9. Records and Release of Information: Providers may use or disclose my health information for treatment, payment, or healthcare operations purposes as described in the National Jewish Health Notice of Privacy Practices, including to any healthcare provider involved in any way in the care of the patient and to any person or entity which may be liable for all or part of the charges for services, goods or facilities provided to the patient. All releases of information are subject to the same laws and regulations as in-person care. Please refer to your most recent executed copy of the National Health Jewish Consent to Treatment documents.

I have read, understand, and agree to the information provided above.

*If your child will **not** be in residence with you at the time of the appointment:*
I give permission for _____ *to receive telehealth therapy while s/he is staying with* _____.
Printed Patient Name

_____

Printed Patient Name | Patient or Responsible Party's Signature | Date

_____

If signed by Responsible Party, please state relationship to patient and authority to consent