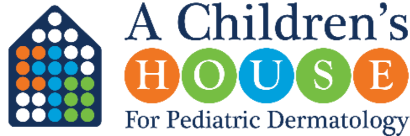
Telemedicine Informed Consent



Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health services to patients when located at different sites. A Children's House for Pediatric Dermatology utilizes doxy.me for these services. Through this platform, all data is encrypted, your sessions are anonymous, and none of your information is stored. They adhere to all HIPAA, PIPEDA, and GDPR data privacy requirements.

1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
2. I understand that this is a remote interaction with the healthcare provider and office staff, and I will not physically be in the same room during the visit.
3. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
   a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my healthcare provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
4. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
   a. I may revoke my right at any time by contacting A Children's House for Pediatric Dermatology at 713-942-9357.
5. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
   a. I understand that A Children's House for Pediatric Dermatology uses a direct patient care model. Thus, they are not contracted with any insurances and will not submit to my insurance for reimbursement on my behalf.
   b. I understand that I will be provided a superbill that includes the necessary codes that I can file with my health plan for possible out-of-network reimbursement, and I realize that payment policies for telemedicine visits may be different from policies for in-person visits.
   c. I understand that I will be responsible for payment of charges for my child's telemedicine visit. My credit card information will be obtained, and payment taken for my appointment when I check in. I authorize that my credit card will be billed with the following charges:

New patient telemedicine visit:	**$200 for up to 30 minutes**
Follow-up patient telemedicine visit:	**$125 for up to 30 minutes**
Emails that may include photos for evaluation:	**$50 per medical issue**

7. I understand that this document will become a part of my child's medical record.

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand; and (3) am located in the state of Texas and will be in Texas during my telemedicine visit(s).

Patient Printed Name	Parent/Guardian Printed Name	Parent/Guardian Signature	Date

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