Informed Consent for Telemedicine Services

1. I hereby consent to Gregory Miranda, MD, a licensed physician in Colorado and Board Certified Pediatrician (hereafter referred to as "Provider"), Pediatrician Next Door, LLC, a pediatric medical practice (hereafter referred to as "Practice"), and other health care providers or the designees as deemed necessary providing health care services to me via telemedicine.
2. I understand the definition of telemedicine is the delivery of medical services and any diagnosis, consultation, treatment, education, or care management using interactive audio, interactive video, or interactive data communication to an individual at an originating site when the Provider is located at a distant site.
3. I understand I retain the right to refuse the delivery of services via telemedicine and to withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment and without risking the loss or withdrawal of any program benefits to which I would otherwise be entitled. I may revoke my consent orally or in writing at any time by contacting the Practice at 970-763-7540, info@PediatricianNextDoor.net, or 2121 North Frontage Rd West #256, Vail, CO 81657. As long as this consent is in force (has not been revoked) for this particular patient, the Practice and the Provider may provide health care services to me via telemedicine without the need for me to sign another consent form.
4. I understand that the laws that protect privacy and the confidentiality of medical information (HIPAA) also apply to telemedicine. As always, your insurance carrier may have access to your medical records for quality review/audit.
5. I understand that, in accordance with Colorado State Law, I shall have access to all medical information resulting from the telemedicine services and may receive copies of this information for a reasonable fee.
6. I understand how the video conferencing technology will be used to effect such a consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as Provider.
7. I understand that I have alternatives to a telemedicine consultation, and in choosing to participate in a telemedicine consultation, I understand that Provider cannot complete some parts of the typical physical exam. If Provider deems certain parts of the physical exam to be of crucial importance for the safety of the patient, then I understand Provider may refer me to an Emergency Room (ER) or other health care provider near me for further evaluation.
8. I understand there are POTENTIAL RISKS associated with the use of telemedicine, as with any medical procedure. These risks include, but may not be limited to:
    a. Interruptions, unauthorized access and technical difficulties. I understand that Provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation;
    b. In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the Provider;
    c. Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
    d. In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
    e. In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reaction or other judgment error;
9. I understand that the EXPECTED BENEFITS may include:
    a. Improved access to medical care by enabling a patient to remain at a remote site;
    b. More efficient medical evaluation and management;
    c. Obtaining expertise of a distant specialist.
10. I understand that Provider will determine whether or not a telemedicine consult is appropriate for my specific medical situation and that I may be referred to a local provider if necessary.
11. In an emergency situation, I understand that the responsibility of the telemedicine consulting provider is to refer me to my nearest ER facility or to advise me to call 911 for EMS (Emergency Medical Services) if necessary and that the telemedicine provider's responsibility will conclude upon the termination of the videoconference connection.
12. I understand that Provider's responsibility will conclude upon the termination of the videoconference connection unless other follow up arrangements have been made.
13. I understand that the Practice has taken reasonable measures to limit the possibilities of data breach and

protect my health information, including, but not limited to, the use of an encrypted and HIPAA-compliant video conferencing platform, use of an SSL encrypted website, and use of encrypted, HIPAA-compliant email server via Proofpoint Essentials. I also understand that, despite these protective measures, there may be risks to the privacy of my health information that are beyond the control of the Practice.

14. I understand that I will hold harmless the Practice and the Provider for information lost due to technical failures.
15. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes.
16. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners (i.e., my primary care provider) who may be located in other areas, including out of state.
17. I understand that my additional express consent will be required in order to forward patient-identifiable information to a third party, except as already described above in 15.

Additional Disclosures for Practice Telemedicine Services

18. I understand the age limits for this service are 0-21 years.
19. I understand that the types of transmissions permitted and services offered via this telemedicine service may include, but are not limited to, discussion of the patient's medical history, patient's current medical issue, pediatric medical advice (symptomatic care, home remedies, instruction in use of over-the-counter medications), issuance of an electronic prescription, issuance of patient education materials, and recommendations for specialist or follow-up care.
20. I understand that Provider provides only discrete general pediatric advice and care that would typically be considered pediatric urgent care services. Provider does not provide longitudinal care, such as routine well child visits, through this telemedicine service, and cannot replace the role of your child's primary care provider. Provider does not provide direct referrals to pediatric subspecialty services. If any such referral seems to be necessary, I understand I will be directed back to my primary care provider to obtain the referral.
21. I understand that there is no guarantee that the patient will require or receive a prescription medication. There are very few scenarios for which prescription medications are appropriate for telemedicine consults. Provider will ONLY provide a prescription medication in such a case where Provider deems the issuance of such a medication to be safe, absolutely necessary, and medically appropriate within the standards of pediatrics. In particular, antibiotic medications will be prescribed only when their use is in accordance with accepted standards of careful and wise antibiotic use. Provider must determine that the anticipated benefits of any medication are likely to outweigh the potential risks (i.e., allergic reactions, side effects, promotion of antibiotic-resistant bacteria).
22. I understand that prescriptions for controlled substances WILL NOT BE ISSUED under any circumstances.
23. I understand that I will receive an invoice from the Practice as soon as possible after services have been rendered and that payment will be due upon receipt.
24. I understand that the Practice does not accept health insurance nor does it provide insurance billing services. However, I will receive a "superbill/receipt" with diagnostic and service codes that I may submit to my health insurance provider should I choose to do so.

By signing this form, I certify:

- That I have identified myself accurately and that I am the legal guardian of the patient for whom I am seeking medical consult
- That the patient for whom I am seeking medical consult and I are physically located within the borders of the State of Colorado and will be present in the State of Colorado during all telemedicine encounters with the Provider
- That I have read or had this form read and/or had this form explained to me
- That I fully understand its contents including the risks and benefits of telemedicine
- That I have been given the opportunity to ask questions and that any questions have been answered to my satisfaction.

_____ _____ _____

Patient/Parent/Legal Guardian Signature Date Time

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Authorized Signer Name & Relationship To Patient