



Telehealth Policy Acknowledgement Form

Patient's Name _____ DOB _____

Parent/Guardian Name _____

- I understand that my provider at Altitude Pediatrics recommends I engage in a telehealth appointment that will be conducted using video conferencing or telephone conference. I understand that this appointment is not the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.
- I understand that there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my healthcare provider or myself can discontinue the appointment at any time if the connections are not adequate.
- I understand that my healthcare provider may share information with other individuals for scheduling and billing purposes. I also understand that all information provided is confidential.
- I understand that chronic conditions and management can often be done over telehealth (ADHD, asthma, anxiety, and depression). Other consults related to development, simple rashes, and behavior can also be done via telemedicine.
- I understand that some parts of the exam including physical tests require in person physical exams. I understand that antibiotics typically will NOT be prescribed via telehealth visits. I also understand that well checks cannot be done via telehealth.
- In an emergency situation, I understand that it is my responsibility to take the advice of the healthcare provider to obtain further evaluation either in the clinic or at the emergency department upon the termination of the telehealth conversation.
- I understand that many insurance companies are now covering provider telephone advice calls and telemedicine visits. However, I also understand that it is my financial responsibility to contact the insurance company prior to telehealth conversations regarding billing and coverage.
- I understand that billing for telehealth consultations is still placed in a schedule for your provider during specific office hours. Telehealth visits will be billed to your insurance and copays will be collected when appropriate.

By signing this document, I acknowledge that I have read all terms and conditions. I also acknowledge that I have had my questions regarding payment, procedures, and treatment explained and I consent to the participation in a telehealth appointment.

Signature of Parent/Guardian _____ Date _____