# All About Kids Pediatrics

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## Informed Consent to Treat Minor Children

**** The law authorizes parent(s) or guardian(s) of a minor to give informed consent for most medical decisions on behalf of the child. All About Kids Pediatrics requires informed consent in order to provide any type of care for patients under the age of 18. By signing below, you authorize and consent to the medical treatment of the patient as is considered necessary by the provider(s) at All About Kids Pediatrics. ****

I, _____, parent or legal guardian of _____, born on _____/_____/_____, do hereby consent to any medical care determined by the provider to be necessary.

This authorization is effective beginning:_____/_____/_____.

Signature of Parent or Legal Guardian: _____

## Informed Consent for Telemedicine Services

***Telehealth is healthcare provided by any means other than a face-to-face visit. All information obtained via telemedicine is used for diagnosis, consultation, treatment, therapy, follow up & education. Telephone consultation, transmission of still images, patient portals & remote patient monitoring are all considered telehealth services.***

**Please note:** Not every patient is right for Telemedicine. These visits are limited in nature and it is important that we verify your child's individual needs will be suitable for a Telemedicine Appointment prior to scheduling. All Wellness Checks (yearly physicals) will be handled as an in office, face-to-face appointment.

- I understand that electronic communication should never be used for emergency communication or urgent / time sensitive requests. Emergency communications should be made to the providers office or to the existing emergency 911 services in my community.
- I understand that I have the right to verify the identity and credentials of the healthcare provider rendering my care via telehealth and to confirm that he or she is my healthcare provider.
- I understand that there is never a warranty or guarantee as to a particular result or outcome related to a condition or diagnosis when any type of medical care is are provided.
- I understand that a medical evaluation via telehealth may limit my healthcare providers ability to fully diagnose a condition or disease. I agree and accept responsibility for following my healthcare providers recommendations- including further testing, therapy, follow ups and the possibility of an in-office visit.
- I understand that telehealth involves the communication of medical/mental health information in an electronic or technology-assisted format & that all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand.

- I agree the information exchanged during my telehealth visit will be maintained by the doctors, other healthcare providers, and healthcare facilities involved in my care. I understand the healthcare provider is not responsible for breaches of confidentiality cause by an independent third party or by me.
- I understand that I have the right to withhold or withdraw my consent to the use of telemedicine during the course my care, without affecting my right to future care or treatment.

**I have read and understand the information provided above regarding telemedicine and all my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.**

This authorization is effective beginning:_____/_____/_____

Signature of Parent or Legal Guardian: _____