Stony Brook Pediatrics
caring for families & children for over 30 years

Telemedicine (Videoconferencing) Consent

1. I consent to participate in a telemedicine (videoconferencing) service with Stony Brook Pediatrics.
2. I understand that this service is not the same as a direct patient/healthcare provider visit, because I will not be in the same room as the healthcare provider performing the service. I understand that there are parts of my treatment and examination which cannot be accomplished because this is not a face-to-face meeting.
3. The nature and purpose of the videoconferencing technology have been fully explained to me. I have also been informed of expected risks, benefits and complications (from known and unknown causes), discomforts and risks that may arise during the telemedicine session, as well as possible alternatives to the proposed sessions, including visits with a physician face-to-face. The risks of not using telemedicine sessions have also been discussed. I have been given an opportunity to ask questions, and all of my questions have been answered fully and satisfactorily.
4. I understand that there are potential risks to the use of this technology, including but not limited to interruptions, unauthorized access by third parties, and technical difficulties. I am aware that either my healthcare provider or I can discontinue the telemedicine service, if we believe that the videoconferencing connections are not adequate for the situation.
5. I agree to permit my healthcare information to be shared with other individuals for the purpose of scheduling and billing.
6. I acknowledge that I have the right to request the following:
   a. Omission of specific details of my medical history/physical examination that are personally sensitive, or
   b. Termination of the service at any time.
7. It is the responsibility of the telemedicine provider to conclude the service upon termination of the videoconference connection.
8. I understand that my insurance will be billed by Stony Brook Pediatrics for the service. I am responsible for any co-payments or deductibles.
9. My consent to participate in this telemedicine service shall remain in effect for the duration of the specific service identified above, or until I revoke my consent in writing.
10. No guarantees or assurances have been made about the results of this service.
11. I confirm that I have read and fully understand the above information. All blank spaces have been completed prior to my signing. I have crossed out any paragraphs or words above which do not pertain to me.

Patient/Relative/Guardian*	Print Name
Relationship to Patient	Date/Time
Witness	Date/Time
Interpreter (if required)	Date/Time

I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives to (including no treatment) the proposed telemedicine session, have offered to answer any questions and have fully answered all such questions. I believe that the patient/relative/guardian fully understands what I have explained and answered.

Physician's Signature	Date/Time