Telehealth Consent Form

As the authorized individual acting on behalf of your child, or as the undersigned patient (the "Patient"), please review this Telehealth Consent Form carefully and acknowledge your understanding, acceptance, and consent by signing below.

I understand that the Patient has the option to receive care via "telehealth", which includes the practice of health care delivery, diagnosis, consultation, counseling, treatment, transfer of medical data, and education using interactive audio, video, or data communications as part of phone or video visits.

I also understand that:

1. I have the right to withhold or withdraw my consent to the use of telehealth during my child's care at any time, without affecting my child's right to future care or treatment.

2. The laws that protect the confidentiality of my medical information also apply to telehealth. As such, I understand that the information disclosed by me or my child during our visits and/or therapy sessions is generally confidential.

3. There are both benefits and limitations to telehealth. Benefits include easier and more flexible access to medical care. Limitations include technical problems, the inability to conduct certain standardized tests/assessments, and limited ability to directly assess vital signs and complete physical examinations.

4. Dr. Cohen may direct me to follow up with my child's primary care pediatrician when appropriate regarding medical concerns that may come up and/or to use local health care facilities/services in cases of emergency or for other procedures that cannot be done through telehealth.

5. I may need to schedule an in-person visit in case of technical failures/difficulties that impact the ability to continue the visit via telehealth, or for further assessment/evaluation that requires direct in-person evaluation.

I have read and understand the information provided above. I have had the opportunity to ask questions about this information, and all my questions have been answered to my satisfaction. I hereby give my informed consent to using/engaging in telehealth with Dr. Cohen through her Developmental Behavioral Pediatrics practice, Samantha Cohen, MD, Inc., as part of the Patient's medical care.

Patient Name: _____ Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____

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