BRIGHTSTAR
Child and Adolescent Psychiatry

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Telemedicine Agreement

- I understand that my health care provider wishes me to engage in a telemedicine (video conference) appointment.
- I understand the video conference will not be the same as a direct patient/health care provider because I will not be in the same room with my health care provider.
- I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties.
- I understand that my health care provider or I can stop the video visit if the video conferencing connections are not adequate for the situation and we may switch to a telephone visit.
- I understand it may be necessary for technicians to be present at certain times during the appointment to help operate the video equipment. Every effort will be made to safeguard protected information obtained (PHI). If showing PHI is unavoidable, confidentiality will be maintained.
- I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes.

I have read or had this form read or explained to me. I fully understand its contents including the risks and benefits of the telemedicine visit. I have been given ample opportunity to ask questions and questions have been answered to my satisfaction.

Patient name	Date of birth
Patient guardian signature	Date