N. Marie Koederitz, MD
Pediatric Ophthalmology & Adult Strabismus

specs
sunflower pediatric eye care & strabismus LLC

CONSENT TO PARTICIPATE IN A TELEMEDICINE APPOINTMENT

1. I understand that Dr. Koederitz wishes me to use Doxy.me for my telemedicine consultation
2. Dr. Koederitz has explained to me how the video conference will not be 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.
3. 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 discontinue the telemedicine consult/visit if it is felt that the Doxy.me video conferencing connections are not adequate for the situation.
4. I understand that my health care information may be shared with other individuals for scheduling and billing purposes. I understand the office will bill and submit a claim to my insurance company.
5. I understand that if others are present during the consultation other than my health care provider, they will maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) Omit specific details of my medical history/physical examination that are personally sensitive to me, (2) ask non-medical personnel to leave the telemedicine examination room, or (3) terminate the consultation at any time.
6. I understand that my video visit will not be recorded but Dr. Koederitz will document the visit in her paper chart. I give consent for her to take photographs during the exam to document parts of the exam and eye findings, also to take photos of paperwork and insurance card.
7. I have had the alternatives to a telemedicine consultation explained to me and in choosing to participate in a telemedicine consultation.
8. I have had a direct conversation with my healthcare provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits, and any practical alternative have been discussed with me in a language in which I understand.

By signing this form I certify:

- That I have read or had this form read and/or had this form explained to me
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Patient Name:

_____

Patient/Guardian Signature:

_____

Print Name: _____

Date: _____

Provider Signature

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