BELLEVILLE LAKE PEDIATRICS
CONSENT FOR TELEHEALTH SERVICES

PATIENT INFORMATION

Patient Full Name: _____

Date of Birth: ____ / ____ / _____

Parent/Guardian Name (if patient is a minor): _____

Relationship to Patient: _____

Email Address: _____

PURPOSE OF TELEHEALTH SERVICES

Belleville Lake Pediatrics (the "Practice") offers telehealth appointments for certain medical services when clinically appropriate, including mental health and medication management follow-up visits, and other services. Telehealth allows patients and families to communicate with providers without being physically present in the office, using real-time, two-way audio-video technology. Telehealth visits are conducted through a HIPAA-compliant platform used by the Practice. At the start of each telehealth visit, the provider will identify himself or herself and his or her professional credentials. Telehealth appointments are intended to supplement, and not replace, in-person medical care and are not appropriate for every medical concern.

BENEFITS, RISKS, AND LIMITATIONS OF TELEHEALTH

I understand that telehealth services may provide convenient access to medical care but have certain limitations, including:

- **Limited Physical Examination.** Providers cannot perform a complete physical examination through video, which may limit the ability to diagnose or manage certain conditions.
- **Technical Difficulties.** Internet connectivity, equipment failures, or other technical issues may interrupt or prevent completion of an appointment. Poor video resolution or audio quality may also cause delays or result in incomplete or inaccurate information being exchanged. If the connection fails, the provider will attempt to reconnect, or the appointment may be rescheduled if needed.
- **Need for In-Person Care.** The provider may recommend or require an in-person appointment, additional testing, or referral when medically necessary.
- **Privacy Considerations.** Although reasonable safeguards are used to protect patient information, electronic communication carries some risk of unauthorized access or technical security issues. I understand that I can reduce these risks by using a private, password-protected device and a secure network whenever possible.
- **Medical Emergencies.** Telehealth is not appropriate for emergencies. Patients experiencing a medical emergency should call 911 or seek emergency medical care.
- **Transmission Errors.** Information transmitted electronically, including images, audio, video, or messages, may be incomplete, distorted, delayed, or misunderstood, which could affect the provider's assessment or recommendations. I agree to ask questions or request clarification if anything is unclear.

PRIVACY AND CONFIDENTIALITY

Belleville Lake Pediatrics uses a telehealth platform with reasonable administrative, technical, and physical safeguards designed to protect patient privacy and confidentiality, consistent with HIPAA and applicable Michigan law. No technology can guarantee complete privacy or security.

I understand that:

- My medical information will be handled in accordance with the practice's Notice of Privacy Practices.
- Telehealth visits will be documented in the patient's electronic medical record, and I have the same rights to access, obtain copies of, and request amendment of those records as for in-person visits.
- The same general confidentiality protections applicable to in-person visits apply to telehealth appointments.
- Under Michigan law, minors may consent on their own to certain services, such as certain mental health, substance use, and reproductive or sexual health care. Parent or guardian access to records of those services may be limited, and providers may speak privately with adolescent patients during part or all of a telehealth visit.
- Telehealth visits will not be recorded by Belleville Lake Pediatrics without advance notice to, and the consent of, the patient or parent/guardian.
- The patient, parent, or guardian agrees not to record any telehealth visit, or allow any third party to record it, without the provider's prior consent.
- Any person present with the patient during a telehealth visit may see or hear health information that is discussed. The provider will identify anyone present at the provider's location, and I am responsible for information disclosed to individuals I allow to be present at my location.
- As with in-person visits, the practice may be required by law to disclose information without my consent in certain situations, such as mandatory reporting of suspected child abuse or neglect and situations involving a serious threat of harm to the patient or others.

PATIENT RESPONSIBILITIES

I agree to:

- Participate in telehealth appointments from a private and appropriate location whenever possible.
- Provide accurate information regarding symptoms, medications, medical history, and other healthcare information.
- Notify the provider if another individual is present during the telehealth appointment.
- If the patient is a minor, ensure that a parent or legal guardian is present or available during the telehealth visit as required by the practice, except where an adolescent patient may lawfully consent to the service independently.
- Follow recommendations for in-person evaluation, testing, or treatment when advised by my provider.
- Use equipment and internet services sufficient to participate in the telehealth visit.
- Not drive or operate a motor vehicle or other machinery during a telehealth visit.

I understand that the provider may verify the identity of the patient and, if applicable, the identity of the parent or legal guardian, before providing medical services.

PATIENT LOCATION, LICENSURE, AND TECHNOLOGY REQUIREMENTS

I understand and acknowledge that:

- Telehealth services may only be provided when legally permitted under applicable laws and regulations.
- My provider is licensed to practice in the State of Michigan.
- I will inform the provider of my physical location at the beginning of each telehealth visit, and I may be asked to verify that location during the appointment.

- Telehealth services generally require that I be physically located in Michigan, or in another state where the provider is licensed or otherwise authorized to provide care, at the time of the visit, and if I am located elsewhere, the visit may need to be rescheduled.
- I am responsible for my own devices, software, and internet or data service used for telehealth visits, including any associated costs.

EMERGENCY CARE ACKNOWLEDGMENT

I understand that telehealth is not intended for emergency medical situations. If the patient experiences a medical emergency, I will call 911, call or text 988 for a mental health or suicidal crisis, or go to the nearest emergency department. For urgent concerns outside of regular office hours, I will follow the practice's after-hours instructions. At the start of each telehealth visit, I will provide the patient's current physical location so that emergency services can be directed to that location if needed. In the event that my provider determines emergency intervention is necessary, then, to the extent permitted or required by law, I authorize Belleville Lake Pediatrics to contact emergency medical services, law enforcement, and/or my emergency contact if reasonably necessary to protect the health or safety of the patient or others.

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: _____

Relationship: _____

Telephone Number: _____

Alternate Telephone Number: _____

Authorization to Contact: I authorize the practice to contact the person listed above if the patient has an emergency during or related to a telehealth visit and to share only the limited information needed to address the emergency, to the extent permitted or required by law.

INSURANCE AND BILLING

I understand that:

- Telehealth appointments are billable medical services and, where applicable, are billed in a manner similar to in-person visits.
- Insurance coverage and patient financial responsibility may vary depending upon the insurance carrier, plan provisions, and services rendered. Coverage for telehealth services, including audio-only visits, varies by insurer, and I am encouraged to check with my insurer regarding coverage before my telehealth appointment.
- I remain responsible for all applicable patient balances pursuant to the Belleville Lake Pediatrics Financial Policy, including deductibles, copayments, coinsurance, and non-covered charges may apply.

PRESCRIPTIONS

I understand that:

- The provider may prescribe medications through telehealth only when clinically appropriate and permitted by applicable state and federal law.
- Medication management may require periodic in-person visits, laboratory testing, or other monitoring.

VOLUNTARY CONSENT

I understand that:

- Participation in telehealth services is voluntary.

- I may decline telehealth services and request an in-person appointment.
- I may withdraw my consent for telehealth services at any time by notifying Belleville Lake Pediatrics.
- Declining telehealth services will not affect my ability to receive care, including medically necessary in-person treatment, or any benefits to which I am otherwise entitled.
- The provider may determine that an in-person appointment is necessary based upon the patient's medical needs.

TELEHEALTH CONSENT ELECTION

Please select ONE of the following:

☐ **I CONSENT** to receive telehealth services from Belleville Lake Pediatrics when medically appropriate.

☐ **I DO NOT CONSENT** to receive telehealth services and prefer in-person appointments.

My choice shall remain in effect unless and until changed or revoked as described in the Voluntary Consent section above.

ACKNOWLEDGMENT

By signing below, I acknowledge that:

- I have read and understand this Consent for Telehealth Services.
- I have had the opportunity to ask questions and receive satisfactory answers.
- I understand the risks, benefits, alternatives, and limitations associated with telehealth.
- I voluntarily make the above telehealth election.
- I understand this consent applies to future telehealth visits until withdrawn as described above, and that my provider may reaffirm my consent verbally at the beginning of a visit as needed.
- I have received, or have been offered access to, the practice's Notice of Privacy Practices.
- I am the patient, or the patient's parent, legal guardian, or other legally authorized representative, and I have the authority to sign this consent on the patient's behalf.
- I may request a copy of this signed consent at any time.

SIGNATURES

Patient (If 18 Years of Age or Older, an Emancipated Minor, or a Minor Consenting to Services the Minor May Legally Consent To)

Signature: X_____

Printed Name: _____

Date**:** ____ / ____ / _____

Parent, Legal Guardian, or Authorized Representative (If Patient Is a Minor Not Consenting on Own Behalf or Otherwise Lacks Capacity to Consent)

Signature: X_____

Printed Name: _____

Relationship to Patient: _____

Authority Document, if applicable (e.g., guardianship order, power of attorney, patient advocate designation): _____

Date**:** ____ / ____ / _____