CONSENT FOR TELEHEALTH SERVICES AND TREATMENT

To our patients and families:

Thank you for choosing us for your telehealth care. Patients and families are essential participants in health care and we want you to understand your rights and responsibilities while receiving care from us. If you have any questions about this form, please ask your provider. If you are a parent/legally-authorized representative of a child, please read this agreement with the understanding that "I" and "me" means the child.

1. Consent for Treatment: I consent to telehealth care performed by my physician and all other associated health care providers at the University of Colorado School of Medicine ("CUSOM") and/ or Children's Hospital Colorado ("CHCO") (the "Providers"). This includes examinations, diagnostic testing, treatment, and other health care services deemed medically necessary in the Providers' professional judgment. I understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may cause injury or even death. I also understand that I have the option to refuse the delivery of health care services by telehealth at any time without affecting my right to future care or treatment, and without risking the loss or withdrawal of any benefits to which I would otherwise be entitled. If I am pregnant, this consent also applies to my fetus.

2. Consent for Telehealth Services: Telehealth involves transmission of video, photographs, and/or details of my medical record such as x-rays and test results (collectively, "Data"). All Data is sent by secure electronic means to the Providers to facilitate the medical service being performed. I understand that:

    - I will be informed of any other people who are present at either end of the telehealth encounter, and have the right to exclude anyone from either location.
    - All confidentiality protections required by law or regulation will apply to my care.
    - I have the right to refuse or stop participation in telehealth services at any time and request alternate services such as an in-person appointment. However, I understand that equivalent in-person services might not be available at the same location or time as telehealth services.
    - If I do not want to receive health care services by telehealth, it will not affect my right to future care or treatment, or any insurance/ program benefits to which I would otherwise be entitled.
    - If an emergency occurs during a telehealth encounter at a hospital or clinic, health care personnel at my location will manage the emergency. If an emergency occurs during a telehealth encounter when I am at a non-health-care site, I should call 911 and stay on the video connection (if applicable) until help arrives.

3. Records and Release of Information: Transmitted Data may become part of my medical record. Data will not be transmitted to people outside my health care team except as described below, and/or if I provide additional written consent.

    - I will have access to all of the information in my medical record resulting from the telehealth services that I would have for a similar in-person visit, as provided by federal and state law.
    - The Providers may use or disclose my health information for treatment, continuity of care, payment, or internal operations, or when required by law or regulation in certain unique situations.
    - All releases of information are subject to the same laws and regulations as in-person care. If I am participating in a human subject research protocol, my medical information may also be released as described in the research consent form(s).

Children's Hospital Colorado
Affiliated with University of Colorado Anschutz Medical Campus

School of Medicine
UNIVERSITY OF COLORADO

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4. Payment Agreement/ Assignment of Benefits: I agree to be responsible for any co-payments, deductibles, or other charges from the Providers and their providers that are not covered or paid by insurance or other third party payors – except as prohibited by any state or federal law, or any agreement between my insurance company and the Providers or University of Colorado Medicine (Faculty Practice Plan ("CU Medicine")). I authorize the Providers and CU Medicine to file any claims for payment of any portion of the patient bills, and assign all rights and benefits payable for health care services to the provider or organization furnishing the services. I agree, subject to state and federal law, to pay all costs, attorney fees, expenses, delinquent charges, and interest in the event the Providers and/or CU Medicine have to take action to collect the same because of my failure to pay all incurred charges in full. It is my responsibility to know what providers and telehealth services are covered under my insurance plan. I understand that I may be billed and agree to pay all bills submitted by the Providers, CU Medicine, and/or other providers involved with the provision of telehealth services.

5. Consent to be Contacted (Telephone Consumer Protection Act): By providing a telephone number (landline or cellular) or other wireless device, I agree that in order for the Providers, CU Medicine, and/or other providers involved with the provision of telehealth services to service my account(s) (including contacting me about appointment reminders, surveys, obtaining potential financial assistance for my account(s)), or to collect any amounts I may owe, the Providers, CU Medicine, and/or other providers involved with the provision of telehealth services may contact me at the telephone number(s) provided which could result in charges to me. I expressly consent that methods of contact may include SMS text messages, phone calls, including automated technology such as an auto-dialing device, pre-recorded messages, and artificial voice messages as applicable. This consent applies to all services and billing associated with my account(s) and is not a condition of purchasing services.

6. If I initial here, I DO NOT consent to being contacted by SMS (short message service) text message and automatically-dialed appointment reminders. _____(Initial here if you do not consent to SMS messages)

By signing this form, I acknowledge that I have read this information and agree to treatment by telehealth.

_____
Printed Patient Name

_____ _____
Patient or Parent/ Legally Authorized Representative Signature Printed Name & Relationship to Patient

_____
Date

A witness is only required if consent is obtained by telephone or video-conferencing:

_____ _____
Name & title of person obtaining telephone or video-conferenced consent Date

_____ _____
Name & title of witness to consent Date

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