Telehealth Patient Consent Form
Lighthouse Pediatrics of Naples, LLC

Patient Name:_____Date of Birth:_____

Purpose: The purpose of this form is to obtain your consent to participate in a telehealth consultation/visit with a healthcare provider at Lighthouse Pediatrics of Naples.
During the telehealth consultation:

a. Details of your child's medical history, examination, x-rays, and tests will be discussed.
b. A physical examination of your child may take place.

Medical Information and Records: All existing laws regarding your access to medical information and copies of your medical records apply to this telehealth consultation. Please note, these telecommunications are not recorded and stored.

Confidentiality: Reasonable and appropriate efforts have been made to eliminate any confidential risks associated with the telehealth consultation, and all existing confidential protections under federal and Florida state law apply to information disclosed during this telehealth consultation.

Rights: You may withhold or withdraw consent to the telehealth consultation at any time without affecting your right to future care of treatment.

Disputes: You agree that any dispute arriving from the telehealth consult will be resolved in Florida, and that Florida law shall apply to all disputes.

Risks, Consequences, and Benefits: You have been advised of the potential risks, consequences, and benefits of telehealth. Your health care practitioner has discussed with you the information provided above. You have had the opportunity to ask questions about the information presented on this form and the telehealth consultation. All your questions have been answered, and you understand the written information provided above. Your insurance will be billed for the telehealth consultation and you understand that any unpaid balance is your responsibility.

I agree to participate in a telehealth consultation for the procedure(s) described above.

Signature: _____Date: _____

Relationship to patient: _____