Children's Hospital
New Orleans
LCMC Health

Children's Hospital School Based Telehealth Program
Consent Form

Student Name: _____

I give my consent for the above listed child to receive telehealth services from a Children's Hospital Physician or Nurse Practitioner. In addition, by signing this form I also understand and agree to the following:

- If a telehealth visit is deemed appropriate, a school representative will attempt to contact those individuals listed below. In the event that both call attempts are unsuccessful, the school representative will proceed with the video visit.
- I authorize the holder of medical or other information about my child to release to any other third party responsible for payment such as information needed for decisions of Medicare, Medicaid, or third party claims.
- I understand that the provider will bill my insurance or Medicaid for these services. I acknowledge that I will be responsible for any payments not covered by my health plan, to include deductibles.
- I have received a copy of the LCMC Health Notice of Privacy Practices for Protected Health Information. An online version of this notice can be found at www.umcno.org/patients-visitors/notice-of-privacy-practices/

In the event that my child needs telehealth services, please contact the following individuals:

Contact 1:

Name: _____

Day Phone: _____

Email: _____

Relationship: _____

Contact 2:

Name: _____

Day Phone: _____

Email: _____

Relationship: _____

☐ **I wish to participate in this program.**

☐ **I do not wish to participate at this time; however, I understand that I will be able to participate in the future if I choose to do so.**

By signing below, I acknowledge that I have read and understand the above information and that this consent allows the Children's Hospital professionals to provide telehealth services. I also understand that I have the right to withdraw this consent at any time through written notice to the school's administration.

Parent/Guardian Signature:_____ **Date:**_____

Parent/Guardian Name Printed:_____

****FOR OFFICE USE ONLY****

By signing below, I confirm that verbal consent to treat was obtained from the legal guardian of the student prior to initiating a video visit. Guardian's signature above acknowledges that verbal consent was given before written consent.

Telehealth Presenter Signature:_____ **Date:**_____