



Telemedicine Services

Demographic Information: (Please Print) School: _____

Patient's Name:

(First): _____ (Middle): _____ (Last): _____

Birthdate: _____ Sex: Male/Female Social Security #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell: _____

Insurance Information:

Primary Insurance: _____ Name of Insured: _____

Insurance ID#: _____ Group: _____

Secondary Insurance: _____ Name of Insured: _____

Insurance ID#: _____ Group: _____

Medical History:

Allergies: _____

Medications: _____

Surgeries: _____

Special Health Needs: _____

HIPAA-ACKNOWLEDGEMENT AND CONSENT TO TREAT

Notice of Privacy Practices and Consent for Ocoee Pediatrics Telemedicine Services

Child's Name: _____

Child's Birth Date: _____

We at Ocoee Pediatrics are required by law to maintain the privacy of and provide individuals with the attached Notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to the Notice, please ask to speak with our office manager in person or by phone at our main phone number. If you would like a copy of the Notice, please ask your child's school nurse.

Initial each line if you agree to the following:

_____ I understand that if my child is experiencing a medical emergency, my child's school will be directed to dial 9-1-1 immediately and that our providers are not able to connect me directly to any local emergency services.

_____ I understand that alternatives to telemedicine consultation, such as in-person services with my child's primary care physician are available and offered to me prior to telemedicine services, and in choosing to participate in a telemedicine consultation, I understand that some parts of these services involving tests (e.g., strep, flu, covid, urine) may be conducted by my child's school system, at the direction of our providers.

_____ I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. I understand that federal and state law requires health care providers to protect the privacy and the security. I understand that Ocoee Pediatrics will take steps to make sure my health information is not seen by anyone who should not see it.

I have carefully read this form and fully understand its contents, including the risks and benefits of the telemedicine services. I acknowledge that I understand and agree with the above and hereby consent for my child to receive care through Ocoee Pediatrics telemedicine services. I understand that telemedicine services rendered by Ocoee Pediatrics does not take place of my child's primary care physician and that I need to continue my child's routine health care needs with their established pediatrician. I hereby acknowledge that I have received the HIPAA Notice of Privacy Practice document.

Signature of Child's Parent/Legal Guardian

Date

Printed name of Child's Parent/Legal Guardian