GREATER SEACOAST COMMUNITY HEALTH

Goodwin Community Health | Families First | Lilac City Pediatrics

Notice to Patients and Consent to Teledental Services Treatment Agreement

1. I understand that telehealth involves the use of an encrypted video application (or via telephone during the COVID19 state of emergency) to communicate with my provider.

2. I understand that teledental visits will be done over a HIPPA-compliant audio/video platform (or via telephone during the COVID19 state of emergency). I understand that information and notes from these visits will be stored in the same way as face-face sessions. I also understand that all patient policies and procedures of GSCH continue to apply.

3. I understand that my insurance will be billed as it is during face-to-face visit. I understand that any copayments associated with my insurance will be billed to me by mail. I understand that if my insurance is found to be inactive I am fully financially responsible for the expenses of the telehealth visit.

4. I understand that I have the right to withhold or withdraw consent at any time without impacting my right to future treatment or risking the loss or withdrawal of any GSCH services to which I would otherwise be entitled.

5. I understand that no personally identifiable images or information from the telehealth visit will be disseminated without my written consent.

6. I understand that the laws that protect the confidentiality of my medical information in face-face visits also apply to telehealth visits. I understand that the information disclosed to me through telehealth during the course of my visit is generally confidential. However, the same mandatory reporting exceptions to confidentiality still apply to telehealth.

7. I understand that it is my responsibility to insure the confidentiality of telehealth visits in the environment in which I participate. I further understand that my provider may also elect to reschedule the visit.

8. Risks related to telehealth visits include certain limits to confidentiality in electronic communication. These risks include, but are not limited to, the possibility, despite reasonable efforts on the part of my provider, that the video (or telephone) interaction between me and my provider could be interrupted due to technical failures or faulty internet connection; and the potential for confidentiality breaches due to technical failures. These risks will be offset with the use of our chosen platform. Furthermore,

when using the video platform, the contents of my provider's computer are encrypted to further ensure my privacy and confidentiality.

ACKNOWLEDGMENT AND ACCEPTANCE

My signature below indicates that I have read and understand this document. This signature also indicates my consent for telehealth services.

Patient Name	Date of Birth
Patient or Guardian Signature	Date
Patient Email	Patient Phone Number
Dentist Signature	Date