Important disclaimer: The AADSM Telehealth Informed Consent form does not protect dentists from liability generally for malpractice or negligence in the performance of medical/dental services. The AADSM Telehealth Informed Consent form is only a model or guideline. Informed consent is governed by the statutes and case law of the individual states where the dentist practices.

INFORMED CONSENT FOR TELEHEALTH SERVICES

Your appointment(s) with (INSERT PROVIDER NAME) will be using telehealth services.

As part of your treatment, remote patient visits may take place over certain platforms that allow for video chats, video, audio and/or photo recordings to be taken of you during the procedures or services.

Please protect your own privacy by being in a private location for this appointment. As always, our office will take your privacy very seriously and will do our best to protect the information you send us.

Some expected **benefits** of this telehealth visit could include:

- The ability to communicate with and be evaluated by your dentist without needing to physically travel to the dentist's office.
- The convenience of being able to communicate with your dentist from a wide variety of locations.

Some possible **risks** of this telehealth visit might include:

- While we believe the risk of privacy breaches are not high, it may be greater than it would be if these services were provided in person. In certain instances, security protocols could fail, causing a breach of privacy of personal medical information.
- In certain instances, lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors.
- While telehealth visits are entirely sufficient in most cases, your dentist may not be able to discover certain underlying conditions that they would be able to during a face-to-face office visit. In rare cases, problems such as poor resolution of images may not allow them to provide appropriate care.
- Delays in evaluation and treatment could occur due to lack of face-to-face visits, records or equipment. Equipment failures, such as dropping of calls, could occur during the session. In case of technology or equipment failures during the telehealth visit, all reasonable efforts will be made to resolve these failures.

Patient obligations and acknowledgements:

- I understand that my dentist wishes me to participate in a telehealth visit and that the same standard of care applies to a telehealth visit as applies to an in-person visit.
- I understand that I will not be physically in the same room as my dentist. I will be notified of and hereby give my consent if anyone is in the room with the dentist.
- I understand that I have the right to withhold or withdraw my consent to use this platform during my care at any time, without affecting my right to future care or treatment.

- I understand my health care information obtained during the telehealth visit may be shared with other individuals for billing and scheduling purposes and to keep referring providers informed.
- I understand that the laws that protect privacy and confidentiality of health care information apply to telehealth services.
- I understand that while certain benefits of this telehealth visit may occur, health results cannot be guaranteed, and it may be necessary to conduct future telehealth visits or in-person visits for treatment.
- I agree that any dispute arising from the telehealth consult will be resolved in (insert proper state) and that that state law shall apply to all disputes.
- I have read this document in its entirety and have had an opportunity to ask questions. Each of my questions has been answered to my satisfaction. If I do not understand this document, I have been offered this document in a different language or have been offered a language interpreter. My family alone is not acceptable to be my interpreter.

Please sign and date below to confirm your agreement with the above statements and to provide your informed consent for the use of telehealth. You will receive a copy of this document for your records, and it will be included in your patient records.

Patient Signature:_____Date: _____

Print Name: _____

If patient is a minor, please sign as Parent or Legal Guardian

Signature:_____Date: _____

Parent or Legal Guardian

Print Name: _____

Witness Signature:_____Date: _____

Print Name: _____

Dentist Acknowledgement
Signature: _____ Date: _____

Print Name: _____

Office Name and Address and Contact Information:

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