TELEDENTISTRY VIRTUAL CONSULTATION

TELEDENTISTRY PATIENT INFORMED CONSENT FORM

(Name of patient or parent/guardian) _____,
agree to participate in a Teledentistry evaluation - consultation.
By signing this agreement, I authorize the electronic transmission of my medical and dental information and/or videoconference session so that it can be viewed by a dentist and other persons involved in my dental health care.
[Note: The likelihood of this transmission being intercepted by persons other than those at the consulting site is extremely small].

- I understand that Teledentistry overall includes the provision of dental health services including, but not limited to, dental health care, diagnosis, treatment, medical data transfer (dental opinion), treatment, consultation, monitoring and / or education using interactive audio communications , video and / or data. Teledentistry includes, with the consent or instruction of the patient under consideration, the communication of his or her medical and dental health information, orally and visually, to other health professionals of the patient's choice and may include any of the following:

  · Medical and records of patient reports
  · Dental images and x-rays
  · Live two-way audio and video (video session)
  · Data from medical devices and audio and video files

  All the information above are confidential.

- I know about risks associated with the use of Teledentistry:

  - The transmitted information may not be sufficient (eg bad picture resolution or connection quality / streaming) to allow reception of appropriate dental healthcare decisions.
  - Delays in evaluation and treatment may occur due to technical failures or interruptions (internet connection, etc.)
  - My dentist is permitted to keep notes during the consultation
  - Failure to access full healthcare records, including dental health records, may result in poor alternative dental treatment plan

- I understand that I can withdraw my permission at any time and that I do not have to answer any questions that I consider being inappropriate or I am unwilling to have heard by other persons. I understand that if I do not choose to participate in a Teledentistry - Teleconsultation session, no action will be taken against me that will cause a delay in my care and that I may still pursue face-to-face consultation.

- I understand that dental health care services are now available with interactive telecommunication and / or electronic information transmission. This process is referred to as "Teledentistry". Teledentistry includes the use of electronic communications so that dentists and other dental health professionals in different locations can share - provide individual medical and dental information and services to patients to improve their oral care

- I understand that as with any technology, Teledentistry does have its limitations. There is no guarantee, therefore, that this teleconsultation session will eliminate the need for me to see a specialist in person. I have been informed that Teledentistry platform protects the confidentiality of patient identification and imaging data and includes measures against hacking. It is forbidden to record an image or sound or combinations.

- I understand that it is my duty to inform for both online and non-electronic interactions about my treatment that I may have with other healthcare providers. (HIPAA ACT6)

- ☂ I understand that in the event of an undesirable response to treatment or in the event of failure to communicate as a result of technical or technological failures, I will seek the continuation of my treatment or the assistance, following a recommendation by the professional.

- ☂ I understand that services and care based on teleconsultation can not produce the same results or be complete as the services provided face to face

- ☂ I understand the benefits of using Teledentistry: Improved and easy access to dental healthcare, avoid travelling difficulties (distance, weather), anytime and anywhere dental health approach, 24/7 of the security of my home

- ☂ I understand that medical and dental records of teleconsultation services will be kept at both the referring site facility and the consulting site facility

- ☂ I understand that some or all of my dental information may be used for teaching or educational purposes. *DECLINE* ☂

- ☂ I agree to have my teleconsultation medical and dental records reviewed for the purposes of evaluation (data collection, analysis and presentation in verbal or written format at scientific meetings). I understand that any presentation will not identify me by name or other identifiable markers. *DECLINE* ☂ (initials of patient)

- ☂ If clinical information regarding HIV status is included in my medical record for purposes of the teledental virtual consultation evaluation, I agree to the collection of these data for research purposes. *DECLINE* ☂ (initials of patient)

- ☂ In case of a dental emergency, I will not signor register in the Teledentistry platform, but must call the Ambulance or go to the nearest hospital as soon as possible

FOR DEMONSTRATIONS ONLY: I agree to permit other persons who are not involved in my dental care to observe my evaluation. I understand that I may withdraw this permission at any time during my evaluation. *DECLINE* ☂ (initials of patient)

☂ For withdrawal from a Teledentistry evaluation, please check the box

Signature of patient (or parent/guardian): _____ Date: _____

Please print the above name: _____

Patient Name: _____

Local MRN: _____ Facility: _____

Signature of patient (or parent/guardian): _____

Date: _____

If you have any questions, please do not hesitate contact with us at the Support Center +30 21 30 333 600 or via email info@teledentistry.eu