TENDERCARE PEDIATRICS
DAVID G. AGUILAR, M.D., F.A.A.P.
7705 Seville Ave., Suite D, Huntington Park, CA 90255
8327 Davis St., Suite 202, Downey, CA 90241

GENERAL CONSENT TO TREAT
OFFICE AND TELEHEALTH SERVICES

I authorize the above stated physician, his associates, assistants and other qualified medical personnel of his/her choice to treat my child and consent to office and/or telehealth services for treatment and care including but not limited to consultations, diagnosis, examinations, immunizations, injections, inhalation treatments, and any other treatment deemed advisable by the physician or his associates and staff.

I understand that in order to receive telehealth services, I must be in California at the time of the service.

I understand that information exchanged during my office or telehealth visit will be maintained by the doctors and other healthcare providers. I also understand that telehealth services carry some risks including that some forms of communication like telephone, Zoom, or other similar services may allow for communication to be forwarded, intercepted, or even changed without my knowledge despite reasonable efforts to prevent this from happening. I understand it is important for me to use a secure network and despite reasonable efforts by my healthcare provider, transmission of medical information could be disrupted or distorted by technical failures.

I understand there are inherent risks of errors or deficiencies in the exchange of health information during telehealth services. My doctor may decide that an in person consultation may be necessary and therefore discontinue the telemedicine visit. Telehealth services should not be used for emergencies. Further, with its risks and limitations no specific results can be guaranteed.

I understand that billing information for telehealth services will be collected in the same manner as a regular office visit. Although my financial responsibility may be determined by my insurance carrier, it is my responsibility to verify with my insurance plan to determine eligibility and coverage. I understand that Tendercare Pediatrics may attempt to check my insurance plan's coverage but ultimately I am financially responsible for all services.

I acknowledge that I have read this consent form and understand its contents. I have had an opportunity to discuss it and ask any questions and I have had my questions answered to my complete satisfaction.

A NOTICE OF OUR PRIVACY PRACTICES IS POSTED IN OUR OFFICE. A COPY OF THIS NOTICE WILL BE PROVIDED TO YOU UPON REQUEST.

Signed: _____ Date: _____

Signature of Parent or Guardian

Witnessed: _____ Date: _____

Patient Name: **DOB:**