Spring Grove Dental

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Informed Consent For Virtual Services

Patient Name:

_____ _____ ____

Last First MI

_____

Preferred Name

Spring Grove Dental will be using remote communication technology to conduct problem-focused evaluations/re-evaluations virtually, to help manage your oral health problem and to determine whether you have a condition that requires immediate in-office treatment. During the current pandemic the federal government announced that it will not enforce HIPAA regulations (privacy for health records) in connection with medical and dental offices' good faith provision of medical or dental services using non-public facing audio or video remote communications services. Remote patient consultations may involve or be based on photos or videos taken with smart phones by the patient and transmitted to the dental office.

Please do not contact us using public-facing services such as Facebook Live, Twitch, or TikTok, which are not permitted by the federal government for this purpose. As always, our office will take dental record confidentiality very seriously, and will do what we can under the circumstances to protect the information you send us. While we believe the risk to such confidentiality is not high, it may be greater than it would be if these remote electronic communications were encrypted, which is one of the main HIPAA requirement that is being relaxed during the nationwide COVID-19 public health emergency.

Certain major dental plans have announced that they will reimburse dental offices for conducting such remote evaluations, and we will submit claims in connection with them. Our dental office is using one or more of the permitted modalities listed above for remote transmission of information to conduct limited problem focused evaluations. While entirely adequate in the vast majority of cases for such limited purposes, these evaluations may not reveal conditions that would be discovered during an office visit or through the use of specialized *teledentistry technology*.

☐ * **Please indicate your understanding of and informed consent to these terms, which will be in effect until the government rescinds its suspension of these HIPAA requirements, by typing your name in the space provided.**

Signature of patient, parent, or guardian: *

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Relationship to Patient:

_____

_____

Response Date: _____