Pediatric Wizards
The Magic of Caring

Please print and email to: pwemail1310@icloud.com

Telemedicine Consent

My child's provider at Pediatric Wizards wishes me to engage in a video visit. The provider has explained to me how this technology will be used and it will not be the same as a direct patient visit. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my provider or I can discontinue the video visit. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation. The above mentioned people will all maintain confidentiality of the information obtained. I understand that billing will occur from my practitioner. I have read or had this form read and explained to me. I fully understand its contents including the risks and benefits. The completed disclosure has been sent to me on the Healow App or Patient Portal.

Print Name:_____ Date:_____

Signed Name:_____ Date:_____

David A. Helft, M.D., M.P.H., F.A.A.P.
1310 W Eau Gallie Boulevard, Suite C, Melbourne, Florida 32935
Office: 321.255.3434 Fax: 321.255.0963
Website: www.pediatricwizards.com