Rauchberg
DENTAL GROUP
A MULTI-SPECIALTY PRACTICE

# CONSENT FORM FOR ONLINE DENTAL CONSULTATION DURING COVID-19

Patient Name: _____

1. I understand that I wish to engage with Rauchberg Dental Group (**RDG**) in a HIPPA compliant online consultation.

2. **RDG** has explained to me how the video conferencing technology will be used as a consultation format during the current COVID-19 Pandemic. It will not be the same as a direct patient/dentist visit due to the fact that I will not be in the same room as the dentist. Furthermore, I understand that this online consultation is being conducted in order to determine if my dental health concerns qualify as a true dental emergency under the Covid-19 protocol set forth by the American Dental Association.

4. I understand that **RDG** may use/share my online consultation information for scheduling and billing purposes. All parties will maintain confidentiality of the information obtained.

5. I understand that I must inform the consulting doctor of another person's presence during my online consultation. Additionally, I understand that I will be informed of any person's presence other than the consulting doctor during my consultation. I understand that this online consultation is being conducted in order to determine if my dental health qualifies as a true dental emergency under the ADA Covid-19 guidelines.

6. I understand that if my dental needs are determined to be a dental emergency by the consulting dentist**,** parts of the exam involving physical tests must be conducted in he **RDG** office at the direction of the consulting dentist

**7**. In an emergent consultation, the **RDG** consulting dentist's responsibilities will conclude upon the termination of the online video consultation connection.

8. I understand that I will be billed by **RDG** for my online consultation.

**By checking and signing this form, I certify:**
_____ That I have read or had this form read to me
_____ That I fully understand its contents.
_____That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

_____ _____
Patient /parent/guardian signature (circle 1) Date

_____ _____
Parent/guardian's printed name Date