Virtual Dental Consent Form (Tele-Dentistry)

I understand a tele-dentistry visit is a virtual appointment with Dr. Melissa Jarrell which will require a mobile phone, email and/or front facing camera on a computer (in a non-public environment) for video conferencing. I understand that this service is intended to provide guidance and recommendations on future dental care.

It can be completed in real-time or via exchange of information which would include photographs that I would need to take of the patient's teeth. I understand I must attach these images as well as any radiographs that I would like reviewed when I complete the patient's paperwork.

I have been informed, understand, and give my consent to have a tele-dentistry/virtual visit with patient and Dr. Jarrell to provide direction, information, and urgency recommendations related to dental needs.

I understand that this visit may or may not be covered by my dental insurance provider and that regardless of that coverage I am responsible for the total charge of $75.00 which must be paid prior to beginning the tele-dentistry/virtual visit with Dr. Jarrell.

I further understand that this not a guarantee that Dr. Jarrell can treat all dental needs for patient at this time or in the future. I understand that in order to accurately and completely diagnose all dental conditions, an in-person clinical dental exam and radiograph(s) would need to be completed at a later date. I understand that each virtual visit is a separate service and if I have further concerns or patient has additional needs in the future, that would involve another visit, either in-person or via tele-dentistry.

I understand that having a tele-dentistry/virtual visit may reduce the frequency/benefit level amounts set by my insurance carrier, if applicable.

I understand that I will not be considered a full/active/comprehensive patient of record of Family and Cosmetic Dentistry of Kokomo until I have completed the full new patient paperwork and signed all applicable consents for in-office based examination and treatments if recommended or required to facilitate necessary care if directed to do so by Dr. Jarrell.

I agree to disclose all current and past medical conditions including illness, conditions requiring regular care from medical providers, medications, allergies and adverse reactions (known or suspected), hospitalizations, symptoms, past dental health history and recommendations given by prior providers for patient.

Printed Name: _____Date: _____

Signature: _____