

## Informed Consent for Telemedicine/Telehealth Consultations

Telemedicine and Telehealth means that you may be evaluated and treated by a health care provider from a distant location via electronic communication. Since this may be different than the type of consultation with which you are familiar, it is important you understand and agree to the following statements:

- The consulting health care provider will be at a different location from me. Additional medical or registration personnel may also be present in the room with the Provider.
- I understand there are potential risks to this technology, including, but not limited to, interruptions, unauthorized access, technical difficulties, and call termination. I understand there are alternatives and limitations to this type of care. I understand that my health care provider or I can discontinue the telemedicine consultation/visit if it is felt that the videoconferencing connections are not adequate for my situation.
- I understand that I may be released before all my medical problems are known or treated and it is my responsibility to make such conditions or symptoms known to the medical personnel as well as to make arrangements for follow-up care.
- I understand that payment/copy will be collected at the time of service and cannot be refunded once the consultation has begun.

### Authorizations

- The undersigned patient, or authorized individual acting on behalf of the patient, understands and agrees as follows: I am granting permission to all physicians, advance practice providers, and any other professionals to perform and administer care and treatment of the patient, or designated other qualified health care provider for such services.
- Grants permission to release to third party payor(s), Medicare, Medicaid, their representatives and/or physician(s) involved in the patient's care, any information needed in connection with all care rendered to patient.
- If the patient is under the age of 18 or lacks capacity, the party affirms that they are either the parent or legal guardian of such patient and has full legal authority to seek medical assistance on behalf of the patient.
- This consent is valid through the end of the calendar year.

### Financial Responsibility

I and/or my insurance carrier(s) agree to pay, in a timely manner, for the health care services provided. I authorize payments directly to Allergy, Asthma & Sinus Care Center doing business as Allergy, Asthma & Food Allergy Centers for all benefits payable. I understand that private and government insurers may not include coverage for this service as a "Covered Service". I further agree to pay the copay that will be requested at the time of my Telemedicine/Telehealth consultation. I understand that I am responsible for any unpaid bills not covered by Medicaid, Medicare, and any other private insurance company(s).

\_\_\_\_\_  
Patient Name and legal guardian if <18 yo (PRINT)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Person Obtaining Verbal Consent  
Print Name:

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Person Witnessing Verbal Consent  
Print Name:

\_\_\_\_\_  
Date