US TELE-MEDICINE
National E-Care Services
Medical Tele-Triage Support

Informed Consent for Telehealth Consultations

To better serve the needs of people in the community, health care services are now available by interactive video communications and/or by the electronic transmission of information. This may assist in the evaluation, diagnosis, management and treatment of a number of health care problems. This process is referred to as “telemedicine” or “telehealth.” This means that you may be evaluated and treated by a health care provider or specialist from a distant location. Since this may be different than the type of consultation with which you are familiar, it is important that you understand and agree to the following statements.

1. The consulting health care provider or specialist will be at a different location from me.

2. The practitioner may transmit or share electronically details of my medical history, examinations, x-rays, tests, photographs or other images with the specialist who is at a different location.

3. I will be informed if any additional personnel are to be present other than myself, individuals accompanying me, the presenting practitioner. L will give my verbal permission prior to the entry of the additional personnel.

4. RELEASE OF INFORMATION: Physicians who provide professional services to the patient are authorized to furnish medical information from my emergency medical record to the referring physician, if any, and to any insurance company or third party payer for the purpose of obtaining payment of the account. The physician is authorized to release information from my medical record to any other health care facility or provider to which my care may be transferred.

6. I voluntarily consent to health care services provided by my doctor(s) or a designee, which may include diagnostic tests, drugs, examinations, and medical treatments considered necessary to treat my health problem.

7. I understand that it is my responsibility to decide follow-up care and make appropriate arrangements.

8. I agree that I am ultimately responsible for the payment of the account and the provider will furnish the proper medical invoice to present to any payor of choice for reimbursement.

9. I understand that I have the option to refuse telehealth service at any time without affecting the right to future care or treatment and without risk of losing benefits.

10. We are happy that you selected us for your healthcare needs and look forward to working with you. To help you understand your financial responsibilities in relation to your medical care, we would like to briefly outline our financial policies.

11. Patients are financially responsible for all services provided and are expected to pay for services at time of service, including any past due balance from a prior date of service. If the patient is a minor child, the parent or other adult accompanying the child will be financially responsible regardless of legal guardianship.

12. Medicare: The office will provide a detailed receipt for payments and that may be submitted to Medicare for reimbursement.

13. Medicare Supplemental and Secondary Insurances: The office will provide a detailed receipt for payments and that may be submitted to Medicare for reimbursement.

14. Medicaid: The office will provide a detailed receipt for payments and that may be submitted to Medicaid for reimbursement. Medicaid patients are responsible for securing necessary referrals from their primary care physicians.

15. HMOs and PPOs, Commercial Insurance Plans: The office will provide a detailed receipt for payments and that may be submitted to your insurance carrier for reimbursement.

16. Self-Pay: Patients are responsible for payment in full at the time of services for all services rendered.

17. Out of State Insurance: The office will provide a detailed receipt for payments and that may be submitted to your insurance carrier for reimbursement.

Authorizations and Consent

ASSIGNMENT AND RELEASE: I also authorize US Telemedicine to release any information required to process my claim to my insurance carrier and/or to my employer or prospective employer (for employer sponsored/paid for claims). I acknowledge that I am financially responsible for services rendered, and failure to pay any outstanding balances may result in collection procedures being taken. Further, I agree that if this account results in a credit balance, the credit amount will be applied to any outstanding accounts of mine, or to a family member whose account I am guarantor for.

I understand the Financial Terms and Authorizations and hereby agree to them:

Signature of Patient/Representative Date

_____ _____

Patient Printed Name Date of Birth

_____ _____

Time _____Site Location:_____