# Patient Financial Policy and Release for Telehealth

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| --- | --- |
| Patient Name**:** |  |
| Date of Birth: |  |

Thank you for choosing us as your health care provider. The following provides an explanation of the additional disclosures and requirements applicable to the delivery of Telehealth services. This document does not replace our Financial Policy and Agreement, which must be read and signed prior to any current and future medical evaluation or treatment in this office.

Many insurance carriers provide coverage for Telehealth or Telemedicine care allowing your care givers to interact with you from a remote location. However, this coverage does vary by insurance carrier. In addition, each insurance carrier typically has a different level of coverage that will vary from plan to plan. With this wide range of coverage and benefits, it is not possible for our staff to know what your plan covers. Therefore, you must contact your insurance plan in order to determine the exact coverage your policy provides.

**Please Read and acknowledge the following**:

While I know that it is my responsibility to understand my health insurance policy’s benefits and coverage, I am requesting a remote appointment regardless of my coverage and benefits provided by my insurance plan. If my insurance plan does not pay for my Telehealth encounter, I understand that it is my responsibility to pay for the appointment.

**[YOUR PRACTICE NAME GOES HERE]** uses technology compliant with current HIPAA guidelines. In order to use Telehealth services, I understand that I must have an internet accessible device with a microphone, speaker and video capabilities. Most modern mobile phones meet these criteria. If I do not have a device that meets these criteria, I understand that I will receive my Telehealth encounter using only a voice-only phone call which may change my insurance plan’s coverage.

I have read this document and agree to the terms of this policy.

**Patient/Parent/Guardian/Patient Representative Signature \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient/Parent/Guardian/Patient Representative Name (Printed) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Name (Printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**INITIATING TELEHEALTH SERVICES**

PLEASE CALL THE OFFICE FOR INSTRUCTIONS AT **[PHONE # TO CALL FOR INSTRUCTIONS]**

**Or**

PLEASE REFER TO THE WRITTEN INSTRUCTIONS PROVIDED TO PARTICIPATE IN YOUR TELEHEALTH ENCOUNTER. PLEASE CALL **[PHONE # TO CALL FOR INSTRUCTIONS]** IF YOU NEED A COPY OF THESE INSTRUCTIONS.

**CONSENT TO OBTAIN TELEHEALTH SERVICES**

* I understand that to fulfill my request for a remote visit, my health care provider wishes me to engage in a telemedicine encounter using **[NAME OF TECHNOLOGY]**.
* My health care provider has explained to me that the **[NAME OF TECHNOLOGY]** will be used to effect the telemedicine encounter and that such an encounter will not be the same as a direct patient encounter due to the fact that I will not be in the same room or location as my provider.
* I understand that there are risks to this technology including interruptions, unauthorized access and technical issues. I understand that my health care provider and I can discontinue the telemedicine encounter if it is felt the [NAME OF TECHNOLOGY] connections are not adequate for the situation.
* I understand that if others are present during the encounter other than my healthcare provider, they will maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the encounter and thus will have the right to request the following:
  + Written documentation of the care I receive via telehealth;
  + Ask non-medical personnel to leave the telehealth encounter room; and/or
  + Terminate the telehealth encounter at any time.
* I have had the alternatives to a telehealth encounter explained to me, and I’m choosing to participate in a [NAME OF TECHNOLOGY] telehealth encounter.
* In an emergency, I understand that the responsibility of the provider engaged in the telehealth encounter is to advise my local practitioner, and that the specialists’ responsibility will conclude upon the termination of the [NAME OF TECHNOLOGY] telehealth encounter connection.

I give permission for you to provide care using a telehealth encounter as described above:

**Patient/Parent/Guardian/Patient Representative Signature \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient/Parent/Guardian/Patient Representative Name (Printed) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient Name (Printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**