



Informed Consent and Financial Responsibility Form for Telehealth Services

This consent is to be implemented for the use of medical services during a declared state of emergency or disaster. This is in coordination of Wavier 1135 under the authority of the Secretary of the Department of Health and Human Services to waive or modify certain Medicare, Medicaid, CHIP, and HIPAA requirements.

Telehealth and telemedicine services involve any telephone consultation, videoconferencing, transmission of still images, e-health technologies, patient portals, virtually e-visit, and remote patient assessment. In telehealth services, medical and mental health information is used for diagnosis, consultation, treatment, therapy, follow-up, and education. Health information is exchanged interactively from one site to another through electronic telecommunications in a secure environment.

Patient Rights:

1. I have the right to refuse to receive services via telehealth without it impacting my ability to receive any other future health care services.
2. I have the right to know the credentials (physician, nurse practitioner, physician assistant) of my provider.
3. I have the right to know who is participating in my telehealth visit.
4. I understand that certain services cannot be provided through telehealth.
5. I understand that there is never a warranty or guarantee as to a particular result or outcome related to a condition or diagnosis when medical care is provided.
6. I understand and agree that a medical evaluation via telehealth may limit my healthcare provider's ability to fully diagnose a condition or disease.
7. I understand that my healthcare provider may choose to forward my information to an authorized third party.
8. I understand that electronic communication cannot be used for emergencies or time-sensitive matters.
9. I agree that I have verified to my healthcare provider my identity and current location in connection with the telehealth services. I acknowledge that failure to comply with these procedures may terminate the telehealth visit.
10. I understand that I must take reasonable steps to protect myself from unauthorized use of my electronic communications by others.

Provider Obligations:

1. I will disclose my name, credentials, and location to you at each visit.
2. I do not have any financial interest in any of the telehealth services, technology, or hardware being used to conduct this visit.
3. I may request that you seek care elsewhere, if I deem telehealth is not appropriate for the condition being diagnosed and/or treated.
4. Prior to the end of our visit, I will explain to you how to obtain follow-up care.
5. A record of this visit is being made you can obtain the records by doing the following: Patient Portal, Medical Records Department or your provider's office.

Telehealth Technology Issues:

1. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are inadequate for the situation. Electronic systems that are accessed by employers, friends, or others are not secure and should be avoided. It is important for me to use a secure network.
2. I understand that Zoom, Skype, FaceTime, or a similar service may not provide a secure HIPAA-compliant platform, but I willingly and knowingly wish to proceed.
3. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Other healthcare team members may also be present during the consultation, other than my health care provider, in order to operate the video equipment. All of whom will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation.

Financial Responsibility:

1. I understand that billing will occur from my provider and the office location in the same manner as a regular office visit:
 - (1) I accept that I am financially responsible for all services rendered on my behalf for which a charge may be associated. I accept personal responsibility for all co-payments, deductibles, and non-covered services, as dictated by my insurance coverage, plus any collection costs for amounts personally owed by me.
 - (2) It is my responsibility to confirm coverage with my payer prior to appointment. I acknowledge that not all services provided by the BVHS are covered by my insurance plan for one or more reasons, including but not limited to exclusions from my insurance plan, my insurance plan's designation of the health system as an out-of-network provider, and/or my failure to provide my insurance card.
 - (3) If Medicare or Medicaid, Worker's Compensation, or similar government program should determine that I am not eligible for coverage, service or treatment, I will be responsible for the payment, unless prohibited by law. Per CMS guidelines, Telehealth Benefits for Medicare and Medicaid Beneficiaries are included during COVID-19 Outbreak.

I certify that I have read and understand this agreement. Due to the nature of the telehealth visit, I will be asked to verbalize consent for treatment with the provider:

Patient Name or Representative Signature

Relationship

Date/Time

Witness – Office Staff or Provider

Date/Time

