Serve the People Community Health Center (STP CHC)

Consent form for

Telehealth Consultations

Patient's Name:		**Date of Birth:**	

To better serve the needs of the people in the community, health care services are now available by interactive video communications and/or by 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. A physician or other health care provider ("presenting practitioner") may be present with me in the room to assist in the consultation.
2. The presenting 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 and, via video, the consultant. I will give my verbal permission prior to entry of the additional personnel.
4. The physician or health care provider for whom the on-site examination or treatment is performed (that is, the "presenting practitioner") will keep a record of the consultation in my medical record.
5. RELEASE OF INFORMATION: STP CHC and/or 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. STP CHC 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 test, drugs, examinations, and medical or surgical treatments considered necessary to treat my health problems.
7. I understand that I may be released before all my medical problems are known or treated and it is my responsibility to make arrangements for follow-up care.
8. I understand that I have the option to refuse telehealth service at any time without affecting the right to further care or treatment.

ASSIGNMENT OF BENEFITS: I and/or my insurance carrier(s) agree to pay, in a timely manner, for emergency and telehealth care services provided. I authorize payment directly to STP CHC of all benefits payable. The benefits assigned include, but are not limited to, the following:

- Primary and secondary benefits for all medical and hospitalization insurance, accident insurance, Medicare, Medicaid, and any benefits payable by alternative delivery systems such as HMOs and PPOs
- Benefits arising from any workers' compensation or occupational disease claims and proceeds to which I am, or my estate is, entitled because of any claim or cause of action for damages against any person or organization.

FINANCIAL RESPONSIBILITY: In consideration for the telehealth services rendered to me, I agree to pay the charges not covered by any insurer or third party payer, including any deductible or co-payment, or any charges not covered as a result of my failure to provide notification or obtain pre-authorization for treatment as required by any insurer or third party payer to STP CHC. Should my account be referred for collection, I agree to pay STP CHC reasonable attorney fees and collection expenses.

By signing below, I certify that I have read, understood, and agree to the telehealth consultation terms and that I have received the STP CHC Notice of Privacy Practices. This consent remains valid indefinitely. It will only need to be signed again if updated by the clinic.

Printed Name of Patient / Parent/ Tutor / Representative	**If applicable, relationship to patient**
Signature of Patient / Parent/ Tutor / Representative	**Date (MM/DD/YYYY)**