Telehealth Consent Form

Patient Information

PATIENT NAME | D.O.B. MM/DD/YYYY | MRN

STREET ADDRESS | CITY | STATE | ZIP

RACE: _____ ETHNCITY: _____

Household Size (Family members directly supported by the guarantor of this household): _____

Household Income (Any income received by any member of the household listed above): _____

Household Status *(Select One)* ☐ Stable ☐ Homeless ☐ Transient Housing

Guarantor Information *(Person responsible for payment and consent)*

GUARANTOR NAME | D.O.B. MM/DD/YYYY

INSURANCE | SUBSCRIBER I.D.

I VERBALLY CONSENT TO TREATMENT: I certify that I am requesting remote/telephonic or virtual examination and medical treatment of the patient by the physicians and employees of the Access Community Health Network. I hereby grant my authorization and consent to any evaluation and treatment and certify that no guarantee or assurance has been made as to the results which may be obtained.

FINANCIAL AGREEMENT AND ASSIGNMENT OF BENEFITS: I verbally hereby authorize payment directly to Access Community Health Network (ACCESS) of all insurance benefits to which I would otherwise be entitled for these services. I understand that I will be obligated to pay for any service not paid for by my insurance including (but not limited to) services that are deemed to be medically necessary.

I verbally accept financial responsibility to Access Community Health Network for 100% of the charges. I will pay any legal fees incurred by Access Community Health Network in collecting this account.

I hereby verbally authorize Access Community Health Network to perform coverage verification at any time to determine coverage eligibility for services rendered. If a valid coverage is discovered, authorization is granted for ACCESS to process all service dates through the discovered insurance for reimbursement for services provided. (Access Community Health Network charges are based on a sliding fee scale according to income and family size. Services are not denied because of an inability to pay.)

RELEASE OF MEDICAL INFORMATION: I hereby verbally authorize release of any medical information in connection with these services for health insurance purposes, or in case of work-related injuries to the patient's employer. Patient verbalized YES: _____ (Staff initials)

AVAILABLE SERVICES: I verbally acknowledge that I have received information regarding the services provided by telehealth provided by Access Community Health Network and that all my questions have been answered to my satisfaction. I understand that if my symptoms or my provider's recommendation require further follow up, I will obtain in-person services at the facilities referred to my provider. Patient verbalized YES: _____ (Staff initials)

TREATMENT METHODS: I verbally acknowledge that I will receive medical advice without the advantage of hands on care and I am responsible for providing all relevant information related to the symptoms or conditions that I am requesting care for. Patient verbalized YES: _____ (Staff initials)

I have been informed that my personal health information may be disclosed without my consent if: (1) there is reasonable cause to suspect a child or vulnerable adult (elderly or disabled) in my care is a victim of abuse; (2) there is reasonable cause to suspect I may cause serious harm to myself or others; or (3) I am diagnosed with a condition that the law mandates be reported for public health purposes.

I have read and fully understand the above acknowledgments and agreements.

NAME OF PATIENT/GUARDIAN PROVIDING VERBAL CONSENT | DATE

SIGNATURE OF STAFF OBTAINING VERBAL CONSENT

ACCESS COMMUNITY HEALTH NETWORK
TRANSFORMING COMMUNITY HEALTH CARE

***See Provider Attestation For 2nd Witness Signature*

PLEASE FILE IN PATIENT'S MEDICAL RECORD