Family Medicine of SayeBrook Consent for Telehealth Services

1) Consent for Treatment: I consent to telehealth care performed by my provider and all associated healthcare workers at Family Medicine of SayeBrook. This includes examinations, treatment, and other health care services deemed medically necessary by the provider. I acknowledge that no guarantees have been made to me as to the result of any exam or treatment. I understand that I have the option to refuse the delivery of telehealth services at any time without affecting my right to future care or treatment.

2) Consent for Telehealth Services: Telehealth involves transmissions of video and includes the exchange of protected health information pertinent to my care that includes but is not limited to test results, patient history, social history, medication management and other data deemed necessary for treatment.

    a. *All confidentiality protections required by law or regulation will apply to my care.*
    b. *I have the right to refuse or stop participation in telehealth services at any time and request an in-person appointment. I understand that in-person services might not be available on the same day.*

3) Records and Release of Information: The details of the Telehealth visits will become part of my medical records. Data will not be transmitted to people outside except as described below, and/or if I provide written consent.
    a. I will have access to all the information in my medical record resulting from the telehealth services that I receive, as provided by federal and state law.
    b. The Providers may use or disclose my health information for treatment, continuity of care, payment, or internal operations or when required by law or regulation in certain unique situations.
    c. All releases of information are subject to the same laws and regulations as in person care.

4) Payment Agreement/Assignment of Benefits: I agree to be responsible for any co-payments, deductibles, or other charges from the Providers and their providers that are not covered or paid by insurance except as prohibited by any state or federal law. I authorize Family Medicine of SayeBrook to file claim for payment and assign any benefits to Family Medicine of SayeBrook. It is my responsibility to know what providers and telehealth services are covered under my insurance plan. I understand that I may be billed for and agree to pay for my portion of telehealth services billed by Family Medicine of SayeBrook.

By signing this form, I acknowledge that I have read this information and agree to treatment by telehealth.

Printed Name: _____ Date of Birth:_____

Patient or Guardian Signature:_____ Date:_____