PENINSULA REGIONAL HEALTH SYSTEM, INC. AND AFFILIATES (PRHS)
HOME TELEHEALTH VISITS
INFORMED CONSENT FORM & FINANCIAL POLICY DISCLOSURE PAYMENT AGREEMENT AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Name: ___________________________________ Phone #_____________________________

Provider Name: ____________________________

1. ______________________________ (name of patient), hereby consents to receive clinical services by **HOME TELEHEALTH VISIT.** A telehealth visit may include the use of telephone, interactive audio, video, audio visual or other telecommunications or electronic technology by a licensed healthcare provider to deliver clinical services within the scope of practice of the healthcare provider at a location other than the location of the patient. Telehealth services may also include the use of interactive audio-visual, store and forward technology, interpretive services and/or remote patient monitoring by a licensed healthcare provider.
2. I consent to receiving services through the PRHS telehealth platform, including but not limited to assessment, intervention, and treatment decisions and recommendations.
3. I consent to the recording and electronic transmission of my medical information and/or videoconferencing session so that it can be viewed by healthcare providers and others involved with my medical or mental healthcare.
4. I understand that the laws that protect the privacy and confidentiality of my personal information also apply to telehealth. Nevertheless, there are privacy and confidentiality risks inherent in technology-based services, including telehealth.
5. I understand that as with any technology, telehealth has its limitations. There is no guarantee, therefore, that telehealth will eliminate the need for me to see a healthcare practitioner in person.
6. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
7. I hereby authorize Peninsula Regional Medical Center (PRMC) to release my diagnosis and other medical information to the third parties in order to secure payment for services rendered by the Hospital, physicians, and other healthcare providers.
8. I hereby authorize direct payment to Peninsula Regional Medical Center of any insurance, personal injury and/or other benefits otherwise payable to me or the patient. The undersigned acknowledges the responsibility for any coinsurance, deductible, an/or other sums not received by the provider from any third-party source.
9. In consideration of the acceptance of the patient named on this form by Peninsula Regional Medical Center, and or the services rendered said patient, the undersigned hereby guarantees payment of any and all charges made by the hospital and/or other healthcare providers for services rendered on behalf of patient.
10. I agree to pay all charges which are not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan.

THIS INFORMED CONSENT FORM FOR TELEHEALTH HOME HAS BEEN FULLY EXPLAINED TO ME, AND I CERTIFY THAT I UNDERSTAND ITS CONTENTS. I HEREBY GIVE MY INFORMED CONSENT TO RECEIVE TELEHEALTH SERVICES. THIS INFORMED CONSENT WILL REMAIN IN EFFECT UNTIL I PROVIDE PRHS/PRMC WITH NOTICE WITHDRAWING MY CONSENT, OR SUCH CONSENT OTHERWISE EXPIRES UNDER THE LAW.

THE FINANCIAL POLICY DISCLOSURE PAYMENT AGREEMENT AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION FOR TELEHEALTH HOME HAS BEEN PROVIDED TO ME AND I CERTIFY THAT I UNDERSTAND ITS CONTENTS.

<u>EMAIL/FAX/ELECTRONIC VERSION:</u> ANY ELECTRONIC VERSION OF A FULLY EXECUTED DOCUMENT SHALL BE DEEMED AN ORIGINAL.

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Patient Date Witness Signature Date