Telehealth Consent Form

Patient Name: ______________________________ DOB: ______________

By signing below I hereby consent to engaging in a Telehealth visit, (also known as a Video Visit) with Family Health Center as part of my medical care. I understand that "Telehealth" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that Telehealth also involves the communication of my medical/mental information, both orally and visually.

I understand the following with respect to Telehealth:

1. My health care provider has explained to me how the video visit technology will be used and that it will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.
2. 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 not adequate for the situation.
3. I understand that the laws that protect the confidentiality of my medical information also apply to Telehealth. (Please see our office privacy policy for more information).
4. I understand that I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
5. I understand that I have a right to access my medical information and copies of medical records in accordance with state law.
6. I understand that my healthcare provider is licensed to practice medicine in the state of Idaho.
7. I understand that I must be an established patient of Family Health Center and that Telehealth services are not currently available to new patients.
8. I understand that Telehealth services may not be a covered benefit under my insurance policy and that I am responsible for verifying if I have these benefits. If I do have these benefits I understand that I am still responsible for any copayments, coinsurances or deductibles.
9. I have been made aware of Family Health Center's financial policy regarding Telehealth visits.
10. I understand that if at any time during the Telehealth visit we are disconnected or the connectivity is insufficient to finish the visit that I will contact Family Health Center at 208-263-1435 to schedule an in person visit with my provider.

By signing this form, I certify:

- That I have read or had this form read or explained to me.
- That I fully understand its contents including the risks and benefits of the Telehealth visit.
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

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Patients / Parent/ Guardian Signature Date

Family Health Center Video Visit Financial Policy 07-01-19

Cash price for a video visit is $61.00. If paid at the time of service we will offer a 15% discount.

For patients who have Medicaid we will bill your insurance and it will be billed at a regular office visit rate.

For patients who have Medicare or a Medicare Advantage plan - Video visits are not currently available unless the patient is willing to sign an ABN and consent form and they understand that they will be responsible for the cost of the visit.

For patients who have other commercial insurance - Please check with your insurance company to see if a Video Visit (telehealth visit) is a covered benefit. We will gladly bill your insurance but at this time most insurance companies are not paying for video visits and you may find that the visit will be denied as patient responsibility and you will be responsible for the entire $61.00 charge. You do have the option to pay cash for the visit and not have us bill your insurance.

If you have any questions please contact our billing department prior to your appointment. We are here to help!