Dear _____:

Welcome to Fanno Creek Clinic and thank you for choosing us for your healthcare needs. Your appointment with _____ is on _____ at _____. Please arrive 15-20 minutes early for your first appointment to complete the check-in process. This initial visit will be to establish care. If you have multiple medical concerns or need a physical exam, you may be asked to schedule a subsequent appointment.

Enclosed you will find information for your review. Be sure to bring the completed health forms to your initial appointment, along with your insurance card. For security and confidentiality reasons, we will ask you for photo identification.

If your insurance company requires you to name a primary care provider, please make sure you have notified them of your new provider. If insurance coverage cannot be verified prior to your appointment, a $100 deposit will be required at the time you check in for that visit. If you have concerns regarding this matter, please feel free to contact our Clinic Administrator, Lane Hickey, ext. 163.

Please note that Fanno Creek Clinic maintains a cancellation and reschedule policy that requires 24 hours notice. Unfortunately, if you fail to provide the required notice more than once, future appointments may not be scheduled. Once established as a patient, failure to provide 24 hours notice 3 times may result in dismissal from the clinic.

For your convenience, directions to our clinic are included in this packet. If you have any questions, please contact our office at (503) 452-0915 or visit us online at www.fannocreek.com. We look forward to seeing you!

Sincerely,

Fanno Creek Clinic Staff

Fanno Creek Clinic
2400 SW Vermont St.
Portland, Oregon 97219
(503) 452-0915
Fax: (503) 768-9232

Fanno Creek Clinic: General Information

Clinic Hours: The clinic is open from 8:00 am until 5:00 pm Monday - Friday.

Emergencies: Dial 911 for life threatening emergencies. During business hours call the clinic and your Doctor or a Nurse will assist you. After hours (5:00 pm – 8:00 am and weekends) you may reach the Doctor on call by calling the clinic and choosing option 2. Leave a message and the Doctor will be paged immediately.

Prescription Refills: Please allow 72 hours (3-5 days) for your prescriptions to be refilled. No narcotics will be refilled after 5:00 pm. Approximately one week before you will be running out, have your pharmacy fax us a request to refill it. Your pharmacist will be able to answer many questions you may have regarding your medication. The fax number is (503) 892-9875.

Same Day Appointments: All requests for appointments the same day you call will be triaged through a Nurse. Although the receptionists cannot make these appointments without authorization from the Doctor or a Nurse, they can make you an appointment for the next available opening.

Lab Hours: The clinic lab is open from 7:30 am until 4:45 pm, Monday – Friday. You need to check in at the reception desk to pick up your lab order form. Check with your insurance for coverage.

Medical Record Transfers: You will need to complete a release of information form before records can be sent or received. You can come into the clinic and fill out the form or you can go to the clinic your records are at (if they are not here) and sign a release there. Please allow approximately 2 weeks for the transfer.

DIRECTIONS TO FANNO CREEK CLINIC

Fanno Creek Clinic is located at **2400 SW Vermont St**, Portland, Oregon 97219. Free parking is available in the parking lot directly in front of the building, offering easy access for our patients.

TRIMET INFORMATION: TriMet bus numbers 1, 44, and 45 stop near our clinic. For further information contact TriMet at 503-238-7433 or visit the web site at: http://www.trimet.org/.

FROM THE EAST:

1. Starting out from **I-84** W/US-30 W, merge onto **I-5 South** via the exit on the left toward Beaverton-Salem.
2. Take **Exit 297** toward **Terwilliger Blvd**.
3. As you approach the traffic light, select the middle lane in order to cross Barbur Blvd.
4. Go **straight** at the intersection, which will put you on **Bertha Blvd**, which is just to the right of the Fred Meyer.
5. Go to the second traffic light and turn **left** onto **Vermont St**.
6. **2400 SW Vermont St** is at the top of the hill on the left.

FROM THE SOUTH:

1. Start out going **north** on **I-5**.
2. Take **Exit 297**. Get into the right lane to avoid getting back on the freeway.
3. Turn **left** at the traffic light onto **Terwilliger Blvd**.
4. Stay in the left lane and turn **left** onto **SW Barbur Blvd/OR-99 W/Pacific Hwy W**.
5. Get into far right lane and turn **right** onto **SW Bertha Blvd** (just before Fred Meyer).
6. Go to the second traffic light and turn **left** onto **Vermont St**.
7. **2400 SW Vermont St** is at the top of the hill on the left.

FROM THE NORTH:

1. Start out going **south** on **I-5**.
2. Take **Exit 297** toward **Terwilliger Blvd**.
3. As you approach the traffic light, select the middle lane in order to cross Barbur Blvd.
4. Go straight at the intersection, which will put you on **Bertha Blvd**, which is just to the right of the Fred Meyer.
5. Go to the second traffic light and turn **left** onto **Vermont St**.
6. **2400 SW Vermont St** is at the top of the hill on the left.

FROM THE WEST:

1. Start out going **east** on **Sunset Hwy/26**.
2. Take the **405 South Exit**.
3. Merge onto **I-5 South** via the exit on the **left**.
4. Take **Exit 297** toward **Terwilliger Blvd**.
5. As you approach the traffic light, select the middle lane in order to cross Barbur Blvd.
6. Go **straight** at the intersection, which will put you on **Bertha Blvd**, which is just to the right of the Fred Meyer.
7. Go to the second traffic light and turn **left** onto **Vermont St**.
8. **2400 SW Vermont St** is at the top of the hill on the left.

OR:

1. Start out going **east** on **Beaverton-Hillsdale Hwy**.
2. Turn **right** onto **30th Ave**.
3. Turn **left** at the light onto **Capitol Hwy/Vermont St**.
4. Turn **right** to stay on **SW Vermont.**
5. **2400 SW Vermont St** will be on your right.

FANNO CREEK CLINIC
Adult Health Questionnaire

GENERAL INFORMATION: Completed by patient, please print:

Name: _____ **SSN#**:_____ **Today's Date**:_____
Date of Birth:_____ **Phone**:_____ **E-Mail**: _____
Emergency Contact Person:_____ **Contact Phone Number**: _____
Marital Status: S ☐ M ☐ W ☐ D ☐ Sep ☐ Partner ☐ **Live With**: _____
Occupation: _____ **Reason for Visit**: _____
Current Concerns: _____
_____
_____

MEDICAL HISTORY: Check current or past problems, indicating date of onset:

☐Glaucoma _____	☐Emphysema _____	☐Arthritis _____
☐Cataracts _____	☐Asthma _____	☐Decreased Hearing _____
☐Tuberculosis/TB	☐Seizures _____	☐Anemia _____
☐Diabetes _____	☐Ulcer _____	☐Emotional Problems_____
☐Thyroid Problems _____	☐Hepatitis _____	☐Depression _____
☐High Blood Pressure _____	☐Liver Problems_____	☐Cancer (type) _____
☐Heart Trouble/Angina _____	☐Kidney Problems _____	☐Heart Attack _____
☐Bladder Problems _____	☐HIV/AIDS _____	☐Stroke _____
☐High Cholesterol _____	☐Blood Clotting _____	
☐Broken Bones/Osteoporosis _____	☐Sexually Transmitted Disease _____	
☐Other_____		

SURGICAL HISTORY: Check type of surgery and date of procedure**:**

☐Appendectomy_____ ☐Cataract Surgery_____ ☐Prostate Surgery_____
☐Hysterectomy (Full: uterus & ovaries)_____ ☐(Partial: uterus only)_____
☐Other:_____

OTHER HOSPITALIZATIONS: Reason & Date: _____
_____

MEDICATIONS: List all medications you are now taking, indicate over-the-counter medications, vitamins & supplements, continue on back if needed:

Name	Strength	How Often

DRUG ALLERGIES: Please list all known drug allergies:
_____
_____

~CONTINUED ON NEXT PAGE~

HEALTH HABITS: Indicate all that apply**:**

Diet: Regular ☐ Fast Foods ☐ Low Fat ☐ Low Salt ☐ Vegetarian ☐

Tobacco: Never Smoked ☐ Smoked ☐ **From ___to ___ Packs/Day** Current ☐ **Packs/Day____**

Alcohol: Never ☐ Occasionally ☐ Regularly ☐ Drinks/Day____ Heavy ☐ In Past ☐Quit ___

Street Drugs: Never ☐ Occasionally ☐ In Past ☐ Type _____Injection Use: Y ☐ N ☐

Sexually Active: Not Active ☐ Monogamous ☐ Multiple Partners ☐ Safe Sex: Y ☐ N ☐

Exercise: Unable ☐ Rarely ☐ Occasionally ☐ Regularly ☐ Type(s):_____

Seatbelt Use: Never ☐ Sometimes ☐ Always ☐ Automatic ☐ Firearms In Home**:** Y ☐ N ☐

FAMILY MEDICAL HISTORY: Indicate health problems & cause of death where applicable. Specify types of cancer, heart disease, diabetes, etc**.**

MEMBER	**LIVING**	**AGE**	**MEDICAL INFORMATION**
Mother	Y ☐ N☐	___	_____
Father	Y ☐ N☐	___	_____
Bro/Sis	Y ☐ N☐	___	_____
Bro/Sis	Y ☐ N☐	___	_____
Bro/Sis	Y ☐ N☐	___	_____

CURRENT HEALTH CONCERNS: Check all recent problems**:**

☐Weight Loss	☐Vomiting	☐Joint Swelling	☐Fevers
☐Diarrhea	☐Chills	☐Constipation	☐Leg Pain (while walking)
☐Hearing Loss	☐Heartburn	☐Rash/Itching	☐Easy Bruising/Bleeding
☐Abdominal Pain	☐Headaches	☐Cough	☐Shortness of Breath
☐Wheezing	☐Incontinence	☐Fainting Spells	☐Bloody/Tarry Stools
☐Chest Pain	☐Dizziness	☐Frequent Urination	☐Painful Urination
☐Palpitations	☐Anxiety	☐Insomnia	☐Vaginal/Penile Discharge
☐Nausea	☐Joint Pain	☐Poor Appetite	☐Sexual Problems
☐Ankle Swelling	☐Other: _____		

IMMUNIZATIONS: Please check with date**:**

☐Tetanus_____ ☐Hepatitis_____ ☐Pneumovax _____ ☐Other_____

WOMEN'S HEALTH: Please complete**:**

Last Pap Test:_____ Normal: Y☐ N☐ Last Mammogram:_____ Normal: Y☐ N☐
Menstrual History: Age of Onset: ____Regular: Y☐ N☐ Last Menstrual Period:_____
Number of Pregnancies: ____Number of Live Births: ____Number of Miscarriages:_____
Current Birth Control Method: _____ Date of Menopause: _____

Fanno Creek Clinic, LLC Financial Policy

The most important and singular goal at Fanno Creek Clinic is to provide you, our patient, with the best and current 'state-of-the -art' medical care available, in a friendly, positive and supportive environment.

The following information outlines your financial responsibilities related to payment for professional services and testing, as you, the patient, are ultimately responsible for all charges associated with your care regardless of insurance coverage. These include, but are not necessarily limited to, ancillary testing, like Laboratory tests and x-ray assisted diagnoses, that your provider deems medically necessary for accurate diagnosis. Fanno Creek Providers believe that a good provider/patient relationship is based on understanding and communication regarding these financial responsibilities.

Patient Responsibilities

- Patients are responsible for all fees at the time of service including co-pays. A $10.00 billing fee will be assessed if your co-pay is not received at the time of service.
- Patients are responsible for providing a current insurance card that has your name and claim submission information. Patients who do not provide insurance information at time of service may be responsible for all charges associated with the visit.
- Patients are responsible for providing Fanno Creek Clinic with up-to date address and other contact information.
- Patients must obtain a referral for outside services. If you choose to be seen at a specialist's office, urgent care clinic, or hospital prior to obtaining valid authorization your visit may not be covered.
- If you have an insurance plan that Fanno Creek Clinic does not participate with we will file a claim for you as a courtesy. However, if payment is not received within 60 days of filing any remaining balance will become patient responsibility and will be due immediately.
- Patients who do not show up for an appointment or cancel an appointment with less than 24 hour notice (by the end of the prior business day) may be assessed a $25.00 fee for each missed visit. Three no-shows and/or same day cancellations may result in dismissal from Fanno Creek Clinic.
- All payments are due within 30 days from the date of Fanno Creek Clinic's initial billing statement.
- Insured patients with an unmet deductible of $500.00 or more who are not currently established with Fanno Creek Clinic (greater than 12 months since the last visit) will be required to pay a $100.00 deposit for any office visit.
- Uninsured patients and patients with out-of-network benefits will be required to pay a deposit of $100.00 for all office visits. All services rendered are patient responsibility and due at time of service.
- Payment plans are available for established patients. Please contact our business office prior to your appointment if you anticipate a need for financial assistance at (503)452-0915, option 5.
- If an account becomes delinquent, it may be assigned to an outside collection agency. Patients are responsible

Psychiatric appointments: *Our psychiatrists require that patients provide, at least two weeks in advance, a deposit of $150.00 (by check or cash). This helps reserve the appointment with your psychiatrist. This deposit is refundable if cancellation notice is given to the clinic or your psychiatrist at least 48 hours prior to your appointment.*

Insurance Billing

Medicare: Our physicians and specialists are Medicare participating providers and we will bill Medicare as your primary insurance. In some cases Medicare may automatically forward the bill to your secondary insurance. We require you to provide us up-to-date secondary insurance information to ensure payment is made in a timely fashion.

Secondary insurance: Fanno Creek Clinic will bill your secondary insurance provided the information is provided up front to ensure timely filing with insurance companies. If insurance information is not provided at time of service you may be responsible for all charges associated with your visit.

Motor Vehicle Accident/Liability Claims: Please notify the front desk when you check in if your appointment is related to an auto, work, or liability claim and provide billing information, including your claim number, prior to being seen. Fanno Creek Clinic requires a $100.00 deposit for all visits related to a motor vehicle accident or liability claim. Any balance remaining is the patient's responsibility.

Agreement

I understand that I, the patient, am ultimately responsible for all charges associated with my visit including, but not limited to, all ancillary charges (lab and x-ray) deemed medically necessary for accurate diagnosis and treatment, including charges from external facilities associated with services provided at Fanno Creek Clinic. My signature below indicates I have read and understand this financial policy and agree to abide by its terms for my treatment at Fanno Creek Clinic, LLC.

_____

Patient Signature (parent/guardian signature if patient is a minor) Date

_____

Printed Name Date of Birth

Financial Policy – Updated Aug 24, 2016

FANNO CREEK
CLINIC

2400 SW Vermont St.
Portland, Oregon 97219
(503) 452-0915

NOTICE: PATIENT PRIVACY

August 24, 2016

We are committed to preserving the privacy of your personal health information. We are required by law to protect the privacy of your medical information and to provide you with notice describing:

HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.

Fanno Creek Clinic may use and disclose the following information without your authorization for the purpose of and relating to: Treatment, Payment, Health Care Operations, Appointments, Treatment Alternatives, Health-related Products and Services, and the following situations: safety; required by law; research; organ and tissue donation; military veterans; national security and intelligence; workers' compensation; public health risks; health oversight activities; lawsuits and disputes; law enforcement; coroners; medical examiners and funeral directors; and information not personally identifiable. Detailed descriptions of the purposes and situations (not all situations will be described) can be found in our current Privacy Notice. The Clinic requests that you sign below as written acknowledgement of this Notice is required.

- As our patient, you have important rights relating to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

- We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligations under the law. We may revise our Notice of Privacy Practices from time to time. The effective date at the top of this page indicates the date of the most current Notice of Privacy Practices in effect.

- You have the right to receive a copy of our most current notice in effect. If you would like to request a copy, please ask at the front desk.

- If you have any questions, concerns or complaints about this notice or your medical information, please contact Lane Hickey, Clinic Administrator, at 503-452-0915 x 163.

_____ _____ _____

Patient Signature: **Date of Birth:** **Date:**

_____

Print Patient Name:

FANNO CREEK
CLINIC

CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION

The Health Insurance Portability and Accountability Act (HIPAA) restricts Fanno Creek Clinic and its employees from releasing protected health information to any individual other than the patient unless the patient indicates consent in writing. If you wish to designate someone other than yourself with whom we may discuss your medical information, diagnostic or laboratory results, and/or financial information please indicate their name, relationship, and contact phone number below:

NAME	RELATIONSHIP	PHONE

By signing below, I, _____, authorize Fanno Creek Clinic to release medical information and/or financial information related to my care to the above named individuals. I understand that I may revoke and/or update this authorization at any time by notifying Fanno Creek Clinic in writing.

_____ _____
Signature of patient/authorized representative Patient's date of birth

_____ _____
Relationship to patient Date

FANNO CREEK
CLINIC

CONSENT TO LEAVE PERSONAL HEALTH INFORMATION BY VOICEMAIL

☑ Please check one of the following:

☐ I give my consent to Fanno Creek Clinic physicians and staff to leave detailed voicemail messages regarding my medical information, diagnostic or laboratory results, and/or financial information at the following phone numbers:

My Home: ( ) _____ My Cell: ( ) _____

☐ I **do not** consent to receiving detailed voicemail messages regarding my medical information at home, on my cell phone, or at any other number.

_____ _____
Signature of patient/authorized representative | Patient's date of birth

_____ _____
Print patient name | Date

_____
Relationship to patient

How did you hear about Fanno Creek Clinic?

Dear Patient,

Welcome to Fanno Creek Clinic! We appreciate you choosing us for your healthcare. Please let us know how you found us.

Have you been a prior patient of one of our Providers at a different location? Y☐ N☐
If so, which Provider? _____

How Did You Hear About Us? Please Check All That Apply:

☐ **Recommendation from Friend**
☐ **Recommendation from Family Member**
☐ **Advertisement** **Publication Name:** _____
☐ **Yellow Pages**
☐ **News Story** **Publication/Outlet:** _____
☐ **Did a Physician refer you?** **Physician Name:**_____
☐ **Insurance List/Referral**
☐ **Website**
☐ **Clinic Sign**
☐ **Promotional Mailing**
☐ **Zocdoc**
☐ **Other; Please Specify:** _____

Comments or Suggestions:

_____

_____

Thank you for taking the time to fill out this form. Please return it to the receptionist.

Sincerely,

Gregg Coodley, MD

Fanno Creek Clinic
Patient Portal User Agreement

Fanno Creek Clinic, (FCC) is pleased to provide you the ability to access parts of your personal medical record by using our Patient Portal Program, (the Patient Portal). By requesting access and set up of a Patient Portal account, you agree to the following terms and conditions:

ELIGIBILITY

In order to participate in the Patient Portal, you must be at least 18 years of age, and an active patient of an FCC physician.

USE OF PATIENT PORTAL

By requesting participation in the Patient Portal, you understand and agree to the following:

a) The Patient Portal is intended as a secure, online means for you to access a limited portion of your personal and confidential medical record.
b) The Patient Portal is not meant to be used in any manner during an emergency. In any emergency situation, you should immediately seek appropriate emergency care.
c) You will use the Patient Portal only as permitted, and not attempt to harm or circumvent any of its security features, or use the Patient Portal for any purpose other than as described in this agreement.
d) The Patient Portal provides access to a limited portion of your medical record. It does not provide access to your complete medical record.
e) The Patient Portal is voluntary; you are not required to use the Patient Portal to receive care from FCC providers. FCC will not condition your treatment or care based on your participation in the Patient Portal.
f) If you wish to discontinue use of the Patient Portal you should contact FCC immediately.

PROVISION OF SERVICES

a) The Patient Portal is being provided as a convenience to our valued patients. FCC will attempt to provide access to the Patient Portal without interruption, but access is provided on an "as is available" basis.
b) FCC cannot guarantee that the Patient Portal will be error-free. Should you have reason to believe that your information contained in the Patient Portal is incorrect, or that there is an error within the Patient Portal, please contact FCC immediately.
c) FCC has the right to terminate your Patient Portal access at any time for any reason. If abuse or negligent use of the Patient Portal occurs, we reserve the right at our own discretion to terminate the Patient Portal offering, suspend user access, or modify services or terms of services offered through the Patient Portal.
d) You agree that FCC takes no responsibility for, and disclaims any and all liability arising from any inaccuracies or defects in the information, software, communication lines, Internet, or your Internet Service Provider (ISP), computer hardware or software, or any other service or device that you use to access the Patient Portal.

PRIVACY POLICY

FCC is fully committed to complying with all federal and state laws and regulations concerning the confidentiality of medical record information. Our HIPAA Notice of Privacy Practices can be found at:

http://fannocreek.com/media/images/patient_forms/privacy.pdf

SECURITY

IMPORTANT: There are certain risks associated with the use of the Internet to access your personal medical information and you acknowledge that you have been advised of these risks. If you have any concerns regarding the security of your information or the use of the Internet to access your medical record information through the Patient Portal, you should consider not creating a Patient Portal account.

a) The Patient Portal is provided in partnership with our Electronic Medical Records (EMR) software vendor and other providers. All Patient Portal data is stored at FCC and is on HIPAA-compliant servers with high level encryption.
b) You should not access the Patient Portal from a public computer or from an unsecured wireless network.
c) You should take steps to ensure that your computer or connecting device is secure and free of malware and/or viruses, and has the latest security updates.
d) You must keep all information (credentials) used to connect to the Patient Portal confidential and secure. If you believe or suspect that the confidentiality of your username, password, or secret questions have been compromised, you should change your password immediately by following the procedures described in the Patient Portal.
e) FCC is not responsible for any breach of your confidential medical record information due to your sharing or losing your user name, password, or the answers to your security questions.

FCC may modify these terms and conditions, other terms and materials referenced in this document, the Patient Portal, or the content of the Patient Portal website at any time. For this reason, you should review these terms and conditions on the website periodically.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with online access of my personal medical record, and consent to the conditions outlined herein. These terms and conditions are governed by and will be interpreted in accordance with the laws of the State of Oregon.

_____ _____

PATIENT NAME (PRINT) **DATE OF BIRTH**

_____

SIGNATURE / DATE

Fanno Creek Clinic
2400 SW Vermont St.
Portland, OR 97219
503-452-0915

FANNO CREEK CLINIC, LLC.

2400 SW Vermont St. Portland, Oregon 97219
Phone: (503) 452-0915 Fax: (503) 768-9232

MEDICAL AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

~PLEASE PRINT~

I, (patient's name): _____ DOB: _____
authorize the disclosure of my health information as identified below:
FROM: [provider's name/ address]:
_____
_____
TO: [recipient's name/address]**:** _____
_____
for the following purpose (s) **[please initial]** : Change of provider _____ Continuity of care_____
"At the request of the patient"_____ or Other (describe initial):_____
_____.
By **initialing** the spaces below, I specifically authorize the use or disclosure of the following health information and records:
_____ Entire medical record (all information)
_____ Billing record
_____ Medical records developed from _____ to _____ [start date/end date]
_____ **other [specify]: _____.
**If the information to be used or disclosed contains any of the following types of information or records listed below, additional laws relating to the disclosure of this information may apply. I agree the following categories must be initialed to be included in this authorization to release information:
_____ **HIV/AIDS related health information/records
_____ **Mental health information/records
_____ **Genetic testing information/records
_____ **Drug/alcohol diagnosis, treatment and/or referral information. [Federal law prohibits the re-disclosure of this health information.] Federal law requires that a description of the kind of information and how much, be included in this request: _____.
_____ ***Psychotherapy notes [If authorization is for the disclosure of psychotherapy notes, it cannot be combined with any other authorization.]

*****REQUIRED:** Except to the extent that action has been taken in reliance of this authorization, I understand that I may revoke this authorization at any time by giving written notice to this provider. **Unless revoked earlier, *this authorization will terminate on*: ***_____***.**

I understand I may inspect or copy any information disclosed under this authorization unless otherwise restricted by law.

I understand that if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulation, the information described above may be prohibited from disclosing my health information under other applicable state or federal laws and regulations.

I understand that the person{s} I am authorizing to use or disclose my information may receive compensation for doing so.

_____ _____
(Signature of Individual or legal Representative) (Date)

_____
(Relationship to Individual)

[A copy of this signed form will be provided to the individual and/or the individual's legal representative]

FANNO CREEK CLINIC

TeleVisit Consent

Patient Name: _____ Medical Record No: _____

1. I understand that my health care provider wishes me to engage in a telemedicine consultation.

2. My health care provider has explained to me how the video conferencing technology will be used to affect such a consultation 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.

3. 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 telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my health care provider and consulting health care provider in order to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following:

(1) omit specific details of my medical history/physical examination that are personally sensitive to me;

(2) ask non-medical personnel to leave the telemedicine examination room: and or

(3) terminate the consultation at any time.

5. I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a telemedicine consultation. I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting health care provider.

6. In an emergent consultation, I understand that the responsibility of the telemedicine consulting specialist is to advise my local practitioner and that the specialist's responsibility will conclude upon the termination of the video conference connection.

7. I understand that billing will occur from my practitioner.

8. I have had a direct conversation with my doctor, during which I had the opportunity to ask questions in regard to this procedure.

My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand. By signing this form, I certify: • That I have read or had this form read and/or had this form explained to me • That I fully understand its contents including the risks and benefits of the procedure(s). • That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

_____ _____ _____

Patient's/parent/guardian signature Date Time

_____ _____ _____

Witness signature Date Time