Informed Consent for Telemedicine Services

Today's Date: _____

Patient Name:_____ Patient DOB:_____

Telemedicine is a way to get health care from home. Telemedicine visits let you and your provider meet by video, web portal, or other technology. This means that you will not be in the same room as your provider. A note about your visit will be placed in your health record and may be shared with others who are helping with scheduling or billing. **Our Providers are licensed for telemedicine services in Washington and Idaho. You must be physically located in Washington or Idaho during your telemedicine visit.**

You may stop the telemedicine visit at any time. Your provider may also stop the visit if they are worried about the connection quality or if they believe that you need to be seen in person.

Risks and other problems may occur such as equipment or internet failure or poor internet connection which could make it hard for the provider to see how you are doing and may result in more time before diagnosis and/or treatment.

Knowing the risks and benefits, I consent to Telemedicine Services with Gilman Family Practice. Depending on my coverage, I understand there may be a **copayment, deductible,** and **cost sharing** for Telemedicine Service. If I have any questions regarding coverage, I understand that it is my responsibility to contact my insurance provider and I agree to pay outstanding balances not covered by my insurance.

The consent is active for a period of one year from today.

_____

Patient/Parent/Guardian Signature

_____

Printed Name if signing for the patient

**Telemedicine Services offered by Gilman Family Practice adhere to HIPAA Privacy and Security laws.*

GILMAN FAMILY PRACTICE (minor child Age 0-12)

PATIENT INFORMATION:

Last Name_____ First Name:_____ Middle Initial:_____

Mailing Address:_____

City:_____ State:_____ Zip:_____

Birthdate:_____ Soc Sec#:_____ Phone#:_____

Gender: _____Male _____Female _____Other/Specify_____

Race: ____White/Caucasian _____Black/African American _____Native Hawaiian/Other Pacific Islander _____Asian _____American Indian/Alaskan Native _____Refused

Ethnicity: _____ Hispanic or Latino _____Non Hispanic or Latino _____Other _____Refused

Mother/Guardian Name:_____ Father/Guardian Name:_____

Pharmacy Name:_____ Location:_____

Emergency Contact:_____ Relationship:_____ Phone#_____

PRIMARY INSURANCE	**SECONDARY INSURANCE**
Ins Co Name:_____	**Ins Co Name:_____**
ID#_____GRP#_____	**ID#_____GRP#_____**
Subscriber Name: _____	**Subscriber Name:_____**
Birthdate:_____Relationship:_____	**Birthdate:_____Relationship:_____**
Employer:_____	**Employer:_____**

ADVANCED CONSENT TO TREAT MINORS AND RELEASE OF BENEFITS INFORMATION

I authorize my insurance benefits to be paid directly to Gilman Family Practice for services provided by them. I understand that the doctor's office will bill my insurance as a courtesy and that I am responsible at the time for service for all copays, deductibles, and noncovered services. I give Gilman Family Practice permission to release my minor child's private health information required for treatment, referrals, payment, claims, and healthcare operations.

ALL COPAYS ARE DUE AT TIME OF SERVICE

I authorize and consent to routine and emergency medical treatment for _____ when deemed necessary by qualified medical personnel. **(Minor's Name)**

Do we have permission to leave a DETAILED message of the minor's medical information on your voicemail?

_____YES _____NO If YES, which phone#?_____

PARENT/GUARDIAN SIGNATURE:_____DATE:_____

CONTINUE ON REVERSE SIDE