

Informed Consent for Telemedicine / Telehealth Consultations

Welch Pasteur Allergy Medical Group Inc.

Telemedicine and Telehealth means that you may be evaluated and treated by a health care provider or specialist from a distant location via electronic communication. Since this may be different from the type of consultation with which you are familiar, it is important you understand and agree to the following statements:

- The consulting health care provider will be at a different location from me. Additional medical or registration personnel may also be present in the room with the provider.
- I understand that my voice and image may be recorded in order to assist the medical or registration personnel and I consent to any such audio and video recording.
- I understand there are potential risks to this technology, including, but not limited to, interruptions, unauthorized access, technical difficulties, and call termination. I understand there are alternatives and limitations to this type of care. I understand that my health care provider or I can discontinue the telemedicine consultation / visit if it felt that the videoconferencing connections are not adequate for my situation
- I understand that I may be released before all my medical problems are known or treated and it is my responsibility to make such conditions and symptoms known to the medical personnel as well as to make arrangements for follow up care.
- I understand that payment will be collected at the time of service (copays) and cannot be refunded once the consultation has begun.

Authorizations

- The undersigned patient or authorized individual acting on behalf of the patient, understands and agrees as follows: By typing my name below, I am granting permission to all physicians, advance practice providers and any other professionals at Welch Pasteur Allergy Medical Group Inc. to perform and administer care and treatment of the patient, or designated other qualified health care provider for such services.
- Grants permission to release to third party payor(s), Medicare, their representatives and / or physician(s) involved in the patient's care, any information needed in connection with all care rendered to patient.
- If the patient is under the age of 18 or lacks capacity, the signing party affirms

that they are either the parent or legal guardian of such patient and has full legal authority to seek medical assistance on behalf of the patient.

Financial Responsibility

I and/or my insurance carrier(s) agree to pay, in a timely manner, for the health care services provided. I authorized payments directly to Welch Pasteur Allergy Medical Group Inc. or Anita Carmen Choy for all benefits payable. I understand that private and government insurers may not include coverage for this service as "covered service". I further agree to pay the copy that will be requested at the time of my Telemedicine / Telehealth consultation. I understand that I am responsible for any unpaid bills not covered by Medicare, and other private insurance company(s)

Patient Name (PRINT)

Signature of Person obtaining Verbal Consent

Date