Ramona Arias, M.D., P.A.
Board Certified
Internal Medicine & Nephrology

PATIENT REGISTRATION FORM

(Please Print)

Welcome!

Title (Mr/Ms/Mrs/Dr)	First Name	M.I.	Last Name		
Street Address (include Apt/Unit/Lot #)		City		State	ZIP Code
Home Phone	Cell Phone	Work Phone		Date of Birth	
Sex ☐ M ☐ F ☐ T	Race	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed		Spouse Name	
Patient Employer Name	Employer Address (street address, city, state, zip)			Occupation	
Emergency Contact Name	Emergency Contact Phone	Emergency Contact Relationship to Patient			
Email (required for Patient Portal)	Local Pharmacy	Mail Order Pharmacy	Language		
Patient agrees to participate in Patient Portal and agrees to participate with Telemedicine? ☐ Yes ☐ No	Authorization for BayCare eHx exchange? ☐ Yes ☐ No Please initial⇨	Authorization for external Rx history? ☐ Yes ☐ No Please initial⇨			

Responsible Party (if other than patient)

First Name	M.I.	Last Name	Relationship to Patient
Street Address	City	State	ZIP Code
Home Phone	Cell Phone	Work Phone	POA (copy of document required) ☐ Yes ☐ No
Employer Name	Employer Address (street address, city, state, zip)		Occupation

Insurance Information

Primary Insurance Company			Phone
Address	City	State	ZIP Code
Insured's Name	ID #	Group #	Date of Birth
Secondary Insurance Company			Phone
Address	City	State	ZIP Code
Insured's Name	ID#	Group #	Date of Birth

Patient Signature **Date**

Print Patient Name

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MEDICAL HISTORY & MEDICATIONS

Print Patient Name: _____

Medical History

☑ *Check All That Apply*

☐	Hypertension (high blood pressure)	☐	Stroke	☐	Arthritis
☐	Hyperlipidemia (high cholesterol)	☐	Heart Attack	☐	Rheumatoid Arthritis
☐	Cancer (resolved)	☐	Coronary Artery Disease (CAD)	☐	Tuberculosis
☐	Cancer (active)	☐	Blood Clot	☐	Hernia
☐	Diabetes: Type ☐ I or ☐ II	☐	Atrial Fibrillation	☐	Chronic Fatigue
☐	Diabetic Neuropathy	☐	Peripheral Artery Disease (PAD)	☐	Mental Illness
☐	Diabetic Retinopathy	☐	Anemia (Chronic)	☐	Herpes: Type ☐ 1 or ☐ 2
☐	Glaucoma	☐	Diverticulosis	☐	Sexually transmitted diseases (STDs):
☐	Osteoporosis	☐	Hepatitis: ☐ A ☐ B ☐ C		
☐	Kidney Disease	☐	GERD		
☐	Gout	☐	Peptic Ulcers		
☐	COPD	☐	Psoriasis/Eczema	☐	Other:
☐	Asthma	☐	Depression	☐	
☐	Thyroid Disease (hyper- or hypo-thyroidism)	☐	Parkinson's Disease	☐	

For conditions checked above, identify physician currently treating:

Condition	Name of Treating Physician	Telephone & Fax Numbers

Vaccines/Immunizations/Disease

☑ *Check All That Apply*

(if in childhood write childhood)

☐	Chicken Pox	☐	Influenza Vaccine
	Date:		Date:
☐	Mumps	☐	Hepatitis Vaccine
	Date:		Date:
☐	Rubella (German Measles)	☐	Rheumatic Fever
	Date:		Date:
☐	Measles	☐	HPV
	Date:		Date:
☐	Polio	☐	Meningitis (viral/bacterial)
	Date:		Date:
☐	Pertussis		Other:
	Date:		
☐	Scarlett Fever		
	Date:		
☐	Tetanus Vaccine		
	Date:		
☐	Shingles		
	Date:		
☐	Pneumonia Vaccine		
	Date:		

Specific to Women

☑ *Check All That Apply*

☐	Pregnant		Birth Control Method/Medication:
☐	Planning Pregnancy		
Number of:			Date of Last PAP:
	Pregnancies - #	☐	Normal Result
	Live Births - #	☐	Abnormal Result
	Miscarriages - #		Date of Last Mammogram:
	Abortions - #	☐	Normal Result
Menstrual Flow		☐	Abnormal Result
☐	Regular		Date of Last Bone Density:
☐	Irregular	☐	Normal Result
☐	Pain/Cramps	☐	Abnormal Result
	Days of Flow - #		Other:
	Length of Cycle - #		
	1st Date Last Period:		
☐	Menopause/Flushing		

Specific to Men

☑ *Check All That Apply*

Date of Last PSA Test:			Other:
☐	Normal Result		
☐	Abnormal Result		

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MEDICAL HISTORY & MEDICATIONS (CONTINUED)

Print Patient Name: _____

Surgical History

☑ *Check All That Apply*

✓	Date	Surgery	✓	Date	Surgery	✓	Date	Surgery
		Gallbladder			Colostomy			Knee Replacement
		Appendectomy			☐ Reversed			☐ Left ☐ Right
		Prostate			☐ Permanent			Colonoscopy
		Mastectomy			Heart Catheterization			☐ Normal Result
		Colectomy			☐ Stents			☐ Abnormal Result
		Hysterectomy			☐ CABG			Other:
		☐ Partial			Hip Replacement			
		☐ Complete			☐ Left ☐ Right			

Family History

☑ *Check All That Apply*

Condition	Father	Mother	Siblings	Children	Father's Parents	Mother's Parents
Alcoholism						
Asthma						
Bleeding Disorder/Blood Clots						
Cancer						
Diabetes						
Glaucoma						
Epilepsy						
Heart Disease						
High Blood Pressure						
Kidney Disease						
Mental Illness						
Migraines						
Osteoporosis						
Stroke						
Thyroid Disease						
Parkinson's Disease						
Other:						

Social History

☑ *Check All That Apply*

Smoking	Drink Alcohol
☐ Currently – Pack Per Day:	Type:
☐ Ready to Quit	Frequency:
☐ Ex-smoker – Date Quit:	How Many Drinks per Episode:
Recreational Drugs	Caffeine - Cups Per Day:
Pain Medication	Religion - Denomination Name:
Drug Name:	Exercise
Drug Strength & Frequency Taken:	Type:
Prescriber's Name:	Frequency
Travel Outside of USA (provide frequency & locations here):	

Medications

Medication Name & Strength	Directions	Medication Name & Strength	Directions

FINANCIAL POLICY

Ramona Arias, M.D., P.A.
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We are pleased to serve you as your health care provider and are committed to your good health. Please understand that payment for our services is considered a part of your treatment and your obligation to us. The following is a statement of our Financial Policy which we require you to read and sign prior to treatment.

All patients must complete our Patient Registration Package before seeing the doctor. FULL PATIENT PORTION PAYMENT IS DUE AT THE TIME OF SERVICE. WE OFFER AN EXTENDED PAYMENT PLAN WITH PRIOR CREDIT APPROVAL.

All Payments Due at Time of Service

INITIALS The office maintains a payment-at-time-of-service policy**. It is your financial responsibility to arrange ahead of time the ability to pay in full at the time of your appointment.** You need to know your insurance policy in advance to know the portion of your visit for which you will be responsible.

Regarding Insurance

INITIALS Regarding insurance plans which we are a participating provider**, all copayments and deductibles are due prior to treatment**. In the event that your insurance coverage changes to a plan which we are not a participating provider, we will not be able to continue as your health care provider.

We cannot bill your insurance company unless you give us clear and accurate insurance information. Your insurance policy is a contract between you and your insurance company; we are NOT a party to that contract. If you have **new insurance or change insurance plans**, **you must provide us with clear and accurate insurance information within 10 days of your visit for your insurance to be billed**. **If information is provided after 30 days, you will be responsible for any visits that may have occurred.**

If your insurance company has not paid an office visit within 90 days, the balance will be automatically transferred to your responsibility at which time you can pay in full or utilize an extended payment plan. **If payment has not been received from you after four bill statements have been sent (also refer to Statements section herein), your account will be forwarded to a collection agency, and you will be discharged from the medical practice**.

Statements

INITIALS We will send a statement to you should you have a balance with our office. If no payment is received within 30 days, an additional statement may be mailed. **You will accrue late charges and postage charges for additional statements**. Although we will try to remind you at each visit of any balance, it is ultimately your responsibility. When you receive an explanation of benefits from your insurance company showing any patient responsibility, you have received your first statement. There will be a $45 charge for checks denied by your bank and returned to this office for any reason. If payment has not been received from you after four bill statements have been sent (also refer to Statements section herein), your account will be forwarded to a collection agency, and you will be discharged from the medical practice. **It is the patient's responsibility to update the office of any and all changes of insurance company address change or information.**

Mentally and/or Physically Incapacitated Patients

INITIALS **The adult accompanying an incapacitated patient, the parents or legal guardians, are responsible for full payment at time of service**. For unaccompanied, nonemergency appointments, treatment will be denied unless payment has been provided at the time of service.

Divorce/Legal Custody Issues

INITIALS **The adult accompanying a patient to our office for an appointment is responsible for payment. Arrangements for court orders or any legal payment arrangements amongst parents/custodians must be worked out BEFORE the appointment.** If a different parent/custodian is responsible for payment, we are not a party to the payment arrangement between parents/custodians. Payment is due in full at the time of appointment, and we will prepare receipt of payment for verification of payment received. The best way to avoid this issue is for both custodians to come with the adult patient to each visit.

Missed Appointment

INITIALS Unless cancelled **AT LEAST 24 HOURS IN ADVANCE OF APPOINTMENT**, our policy is to charge the person for whom the appointment was made at the rate of $45 for each missed appointment. Please help us to serve our entire patient population best by keeping scheduled appointments. **Patients who miss three (3) or more appointments without notice will be dismissed from this medical practice.**

All Forms

INITIALS **Patient agrees all forms (e.g. disability, FMLA, disabled parking permits) require an office visit to complete the form with the provider).**

Medicare

INITIALS Patient and Provider agree to accept Medicare assignment of 80% of the Medicare allowable fee. However, the remaining 20% will be billed to secondary insurance. Patient will be responsible for the 20% if there is no secondary insurance or if the secondary insurance denies payment. **Patient are responsible to update insurance every year to medical office.**

INITIALS ***Patient agrees to provide this office with completed New Patient Registration Package at least three (3) days prior to patient's scheduled office visit to establish including current photo identification and current insurance card(s) or the appointment to establish will be rescheduled.***

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read, understand, and agree to this Financial Policy:

Patient Signature **Date**

Print Patient Name

PATIENT PORTAL

Ramona Arias, M.D., P.A.
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Internal Medicine & Nephrology

Welcome to Our Office!

Dr. Arias and her staff extend a warm welcome to you as we thank you for choosing us as your health care provider. Our goal is to form a partnership to achieve personal wellness through compassionate, modern medical care one patient at a time.

Patient care is our highest priority!

Please visit our Patient Portal at www.RamonaAriasMD.com.

Secure and available for your use 24/7 to update your information, send messages to our staff, view your medications, laboratory or imaging results, even update your preferred pharmacy. During normal business hours, you can contact us by using the secure Patient Portal or call us at 727-526-9019. If you send us a message through the Portal when our office is closed, it will be addressed during normal business hours by our staff. ***The Patient Portal is not a means for medical treatment; its primary purpose is for communication and information.***

I, the undersigned,

- ☐ do not have an email address.
- ☐ decline to provide an email address to access the Patient Portal.

_____ _____

Patient Signature **Date**

_____

Print Patient Name

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MEDICAL RECORDS

★★ THIS SECTION FOR MEDICAL OFFICE USE ONLY★ ★----------

I hereby authorize Ramona Arias, M.D. **to Obtain** My Medical Records From*:*	*I hereby authorize Ramona Arias, M.D.* **to Release** My Medical Records To:
Name:	Name:
Phone:	Phone:
Fax:	Fax:
Name:	Name:
Phone:	Phone:
Fax:	Fax:
Name:	Name:
Phone:	Phone:
Fax:	Fax:
Name:	Name:
Phone:	Phone:
Fax:	Fax:
Please fax or mail records to: Ramona Arias, M.D., P.A. 4880 49th Street North St Petersburg, FL 33709 Fax: 727-522-7171	Other:

Information Requested

	Hospital Admission Report		Medication List
	Hospital Consult Report		Recent History & Physical
	Hospital Discharge Summary		Demographic Information
	Radiology Reports		AIDS/HIV Reports
	EKG		All of the Above
	Laboratory Reports		All Records
	Other:		

★★ THIS SECTION TO BE COMPLETED BY PATIENT ★★----------

Print Patient Name — Date of Birth

Patient Signature — Date Requested:

Legal Guardian or POA Signature*

Witness Signature

* Authorization must be signed by the patient or legal representative if patient is physically or mentally incompetent.

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MEDICAL RECORDS (FOR INITIAL VISIT)

As a new patient to the office of Ramona Arias, please use this form to authorize Dr. Ramona Arias to obtain your medical records from your previous Primary Care Physician as well as other doctors and/or medical facilities.

I hereby authorize Ramona Arias, M.D. **to Obtain** My Medical Records From***:***	
Name:	Name:
Phone:	Phone:
Fax:	Fax:
Name:	Name:
Phone:	Phone:
Fax:	Fax:
Name:	Name:
Phone:	Phone:
Fax:	Fax:

Patient Signature **Date**

Print Patient Name **Date of Birth**

Please fax or mail records to:
Ramona Arias, M.D., P.A.
4880 49th Street North
St Petersburg, FL 33709
Fax: 727-522-7171
Phone Contact: 727-526-9019

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RECORD OF DISCLOSURES

In general, the **HIPAA (Health Information Portability and Accountability Act) privacy rule** gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. Therefore, the following information needs to be included in your health record.

The privacy rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of and request for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses of disclosures made pursuant to an authorization request by the individual.

Note: Uses and disclosures for TPO (treatment, payment and healthcare operations) may be permitted without prior consent in an emergency.

I wish to be contacted in the following manner: ☑ *Check All That Apply*			
Home Telephone *(please provide number here)*:		Work Telephone *(please provide number here)*:	
	Ok to leave message with detailed information.		Ok to leave message with detailed information.
	Leave message with call back number only.		Leave message with call back number only.
	Written Communication		Other
	Ok to mail to my Home Address		
	Ok to fax to this number:		
	Ok to mail to my Work/Office Address		
	(please provide address here):		

Patient Signature **Date**

Print Patient Name

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LIVING WILL

-Suggested form of a Living Will, Florida Statutes Section 765.303-

A Living Will may, but need not, be in the following form.

Living Will

Declaration made this _____ day of _____, 20___, I, _____ _____, willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that, if any time I am incapacitated, and

- ☐ I have a terminal condition,
- ☐ I have an end stage condition,
- ☐ I am in a persistent vegetative state,

And if my attending or treating physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

In the event that I have been determined to be unable to provide, express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate, as my surrogate to carry out the provisions of this declaration:

Name _____

Address _____

City _____ State _____ ZIP _____

Telephone _____

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

Additional Instructions (optional):

_____ _____

Patient Signature **Date**

_____

Print Patient Name

_____ _____

Witness Signature **Print Witness Signature**

Street Address_____
City, State & ZIP_____
Telephone_____

_____ _____

Witness Signature **Print Witness Signature**

Street Address_____
City, State & ZIP_____
Telephone_____

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DESIGNATION OF HEALTH CARE SURROGATE

-Suggested form of a Living Will, Florida Statutes Section 765.203-

In the event that I have been determined to be incapacitated and unable to provide informed consent for medical treatment, surgical or diagnostic procedures, **I, _____ *(print patient name),*** wish to designate the person(s) identified here as my surrogate for health care decisions:

Print Name _____

Street Address _____

City _____ State_____ ZIP _____

If my surrogate is unwilling or unable to perform his or her duties, I wish to designate as my alternate health care surrogate:

Print Name _____

Street Address _____

City _____ State_____ ZIP _____

I fully understand that this designation will permit my designee to make health care decisions and to provide, withhold, or withdraw consent on my behalf, or apply for public benefits to defray the cost of health care, and to authorize my admission to or transfer from a health care facility.

Additional Instructions (optional):

I further affirm that this designation is not being made as a condition of treatment or admission to a health care facility. I will notify and send a copy of this document to the following persons other than my surrogate and alternate surrogate, so they may know who my surrogate is.

Print Name _____

Print Name _____

Print Name _____

_____ _____

Patient Signature **Date**

_____ _____

Witness Signature **Print Witness Signature**

_____ _____

Witness Signature **Print Witness Signature**

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Internal Medicine & Nephrology

UNIFORM DONOR FORM

-Suggested Uniform Donor Form-

I, _____*(print patient name),* the undersigned, hereby make this anatomical gift, if medically acceptable, to take effect upon my death. The words and marks below indicate my desires:

I give:

- ☐ any needed organs or parts for the purpose of transplantation, therapy, medical research or education.
- ☐ only the following organs or parts for the purpose of transplantation, therapy, medical research or education:

_____

_____

_____

_____

- ☐ my body for anatomical study if needed. Limitations or special wishes *(if any)*:

_____

_____

_____

_____

Signed by the donor and the following witnesses in the presence of each other:

_____ _____

Patient Signature **Date**

_____

Print Patient Name

_____ _____

Witness Signature **Print Witness Signature**

Street Address_____
City, State & ZIP_____
Telephone_____

_____ _____

Witness Signature **Print Witness Signature**

Street Address_____
City, State & ZIP_____
Telephone_____

You can use this form to indicate your choice to be an organ donor, or you can designate it on your Florida Driver's License or State Identification Card at your nearest Florida Driver's License office.

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NOTICE OF PRIVACY POLICIES FOR ALL PATIENTS

-This notice describes how information about you may be used and disclosed as well as how you can get access to this information.
Please review it carefully.

Introduction
At Ramona Arias, M.D., P.A., we are committed to treating and using Protected Health Information (PHI) about you responsibly. This Notice of Health Information Practices describes the personal information we collect and how and when we use or disclose that information. It also describes your rights as they relate to your PHI. This Notice is effective October 16, 2002, and applies to all PHI as defined by federal regulations.

Understanding Your Health Record/ Information
Each time you visit Ramona Arias, M.D., P.A., a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- ☑ basis for planning your care and treatment,
- ☑ means of communication among the many health professionals who contribute to your care,
- ☑ legal document describing the care you received,
- ☑ means by which you or a third-party payer can verify that services billed were actually provided,
- ☑ a tool in educating health professionals,
- ☑ a source of data for medical research,
- ☑ a source of information for public health officials charged with improving the health of this state and the nation,
- ☑ a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights
Although your health record is the physical property of Ramona Arias, M.D., P.A., the information belongs to you. You have the right to:

- ☑ obtain a paper copy of this notice of information practices upon request,
- ☑ inspect and copy your health record as provided for in 45CFR164.524,
- ☑ amend your health record as provided in 45CFR164.528,
- ☑ obtain an accounting of disclosures of your health information as provided in 45CFR164.528,
- ☑ request communications of your health information by alternative means or at alternative locations,
- ☑ request a restriction on certain uses and disclosures of your information as provided by 45CFR164.522, and
- ☑ revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities
Ramona Arias, M.D., P.A., is required to:

- ☑ maintain the privacy of your health information,
- ☑ provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- ☑ abide by the terms of this notice,
- ☑ notify you if we are unable to agree to a requested restriction, and
- ☑ accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all PHI we maintain. Should our information practices change, we will mail a revised notice to the address you have supplied us, or if you agree, we will email the revised notice to you.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or to disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or Report a Problem
If you have questions and would like additional information, you may contact the practice's Privacy Officer, or with the Office for Civil Rights (OCR), U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the OCR. The address for the OCR is listed below.

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building
Washington, D.C. 20201

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment.
For example: Information obtained by a nurse, physician or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you.

We will use your health information for payment.
For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.

We will use your health information for regular health operations.
For example: Members of the medical staff may use information in your health record to assess the care and outcomes regarding your health care.

Medical Community
For example: We may use or disclose information to Emergency Rooms, radiology services, laboratories, etc., so they can perform the job we have asked them to do and bill you or your third-party payer for services. To protect your health information, we require the facilities to appropriately safeguard your information.

Communicate with Family
For example: We may use or disclose information to notify or assist in notifying your location and general condition to a family member, personal representative, or another person responsible for your care. Members of our staff, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Public Health
For example: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Law Enforcement
For example: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena. Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

Funeral Directors
For example: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Print Patient Name

Patient Signature

Date Signed

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Internal Medicine & Nephrology

DESIGNATION OF PERSONAL REPRESENTATIVE WITH ACCESS TO HEALTH INFORMATION

Patient Name (Print) _____

Patient Street Address _____

City _____ State_____ ZIP _____

Cell Phone: _____ Home/Work Phone: _____

I, the undersigned patient or guardian of patient of Dr. Ramona Arias, designate the person(s) listed below as my personal representative(s) and understand and acknowledge that this designation gives the personal representative(s) the same power over my protected health information as I have, including the right to inspect my records, authorize disclosures, and request restrictions and amendments to my records. I hereby waive any restrictions on my personal representative(s) access to my protected health information. I understand that I am not required to list anyone. I also understand this designation shall remain in place until such time as I revoke it in writing by letter to the office of Dr. Arias or by completing a Removal of Designation of Personal Representative form provided to you by the office of Dr. Arias.

Personal Representative Information:

Print Name: _____

Ramona Arias MD
Medical Office Telemedicine Consultation

Print Patient Name: _____

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 wilt occur from both my practitioner and as a facility fee from the site from which I am presented.
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: _____

☐ **I give my authorization to have medical telemedicine visit's with my medical provider and I also agree that this form is subject to change without notice.**

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