



THE COMPASS CLINIC

Specializing in Memory and Movement

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Informed Consent for TeleHealth Consultations

"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 than 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 is 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 or 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 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, therapist, laboratories, and any other professionals 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.
- Understand that this is a temporary service offered to patient due to current state of emergency.
- If the patient lacks cognitive capacity, the signing party affirms that they are authorized to, and have 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 emergency health care services provided. I authorize payments directly to Compass Clinic for all benefits payable. I understand that most private and government insurers do not include coverage for this service as a "Covered Service". I understand that I am responsible for any unpaid bills not covered by Medicaid, Medicare, and any other private insurance company(s).

Patient Name/Authorized Person Name

Signature

Date

Applied to Date of Service: _____