Informed Consent for Telehealth Consultations

North Shore Neurology & EMG Tele-visit Program affords patients the opportunity to complete Televisit appointments from the comfort of their own home or any appropriate internet access point. The program is open to select patients who meet the requirements to complete the tele-visit appointments.

The interactive video communications and/or by the electronic transmission of information may assist in the evaluation, diagnosis, management and treatment of a number of health care problems. This process is referred to as “telemedicine” or “telehealth.” This means that you may be evaluated and treated by a health care provider or specialist from a distant location. Since this may be different from the type of consultation with which you are familiar, **it is important that you understand and agree to the following statements.**

1. I acknowledge that North Shore Neurology & EMG tele-visits are for routine, nonurgent medical conditions, and are not designed, intended, or appropriate to address serious, emergent, or life-threatening medical conditions. I will not attempt to use my tele-visit to address these conditions. If I am having a medical emergency, I will discontinue my tele-visit and call 911 or go to the nearest emergency department. If I am experiencing significant pain, breathing trouble, dehydration, or any other distress that requires immediate or urgent attention, I will discontinue my tele-visit and call 911 or go to the nearest emergency department.
2. I acknowledge that I have agreed to comply with the requirements of this program and understand that the selection to participate, and continued participation, is subject to the program requirements and periodic review by the treating provider, staff, and administration. The Provider reserves the right to refer me back to an in-person visit if conditions change or because of non-compliance.
3. I acknowledge that I will be asked questions regarding the condition for which I am seeking medical care, and that I am obligated to answer questions truthfully.
4. I agree that I will answer these questions completely and accurately and that, if I cannot understand a question or do not know the answer to a question, I will stop my Tele-visit and schedule an in-person visit.
5. I voluntarily consent to health care services provided by my doctor(s) or a designee, which may include diagnostic tests, drugs, examinations, and medical or surgical treatments considered necessary to treat my health problem.
6. I acknowledge that I should be in a secure environment (not a restaurant, lobby, etc.) for the visit, and that it is my responsibility to ensure the privacy of my information on my computer/device.
7. I acknowledge, If my insurance does not cover this service, that I have agreed to "self-pay" for these specific Tele-visit services provided to me through North Shore Neurology & EMG, and I will be responsible for payment in full via a credit card. I would be responsible for the charge of $75.00 for an established patient and $150.00 for a new patient consultation.
8. I acknowledge that I am solely responsible for maintaining the safety and security of my login ID and password.
9. I understand that I may be released before all my medical problems are known or treated and it is my responsibility to make arrangements for follow-up care.
10. I understand that my Tele-visit provider is not able to provide care for all conditions, and I may need to schedule an in-person appointment with a provider.
11. I acknowledge that I have read and understand this disclaimer, Hale Health terms and conditions, and privacy policy that apply to the Tele-visit made available through the Hale Health software platform.
12. I understand that I have the option to refuse telehealth service at any time without affecting the right to future care or treatment.

CONSENT FOR TREATMENT:

I hereby consent to the use of the information I supply as part of the Tele-visit interview by physicians, non-physician advanced practice clinicians (e.g. nurse practitioners, physician's assistants and other advanced clinicians licensed to provide health care services in the State of Massachusetts), and/or other specialists to assess my condition and recommend an appropriate course of care.

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RELEASE OF INFORMATION:
North Shore Neurology & EMG and/or physicians who provide professional services to the patient are authorized to furnish medical information from my emergency medical record to the referring physician, if any, and to any insurance company or third party payer for the purpose of obtaining payment of the account. North Shore Neurology & EMG is authorized to release information from my medical record to any other health care facility or provider to which my care may be transferred.

ASSIGNMENT OF BENEFITS:
I and/or my insurance carrier(s) agree to pay, in a timely manner, for health care services provided. I authorize payment directly to North Shore Neurology & EMG all benefits payable.

FINANCIAL RESPONSIBILITY:
In consideration for the telehealth services rendered to me, I agree to pay the charges not covered by any insurer or third party payer, including any deductible or co-payment, or any charges not covered under my plan and/or as a result of my failure to provide notification or obtain preauthorization for treatment as required by any insurer or third party payer to North Shore Neurology & EMG. Should my account be referred for collection, I agree to pay North Shore Neurology & EMG reasonable attorney fees and collection expenses.

_____ _____
Patient Printed Name Date of Birth

_____ _____
Signature of Patient/Representative Date