AUTHORIZATION AND CONSENT TO PARTICIPATE IN TELEMEDICINE CONSULTATION

The purpose of this form is to obtain your consent to participate in a telemedicine consultation with Coia Comprehensive Primary Care, LLC

1. **Purpose and Benefits:** The purpose of telemedicine is to enable patients to get medical care by specialists without the inconvenience of traveling to the medical facility and meeting in person.

2. **Nature of Telemedicine Consultation**: During the telemedicine consultation:
   a) Details of you and your medical history, examinations, x-rays, and tests will be discussed with health professionals through the use of interactive video, audio and telecommunications technology.
   b) Physical examination of you may take place.
   c) Nonmedical technical personnel may be present in the telemedicine studio to aid in video transmission.
   d) Video, audio, and/or digital photo may be recorded during the telemedicine consultation visit.

3. **Medical Information and Records:** All existing laws regarding your access to medical information and copies of your medical records apply to this telemedicine consultation. Additionally, dissemination of any patient-identifiable images or information from this telemedicine interaction to researchers or other entities shall not occur without your consent, unless authorized under existing confidentiality laws.

4. **Confidentiality:** Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation. All existing confidentiality protections under federal and Rhode Island State law apply to information disclosed during this telemedicine consultation.

5. **Risks and Consequences:** The telemedicine consultation will be similar to a routine medical office visit, except interactive video technology will allow you to communicate with a physician at a distance. At first you may find it difficult or uncomfortable to communicate using video images. The use of video technology to deliver healthcare and educational services is a new technology and may not be equivalent to direct patient to physician contact.

6. **Rights.** You may withhold or withdraw consent to the telemedicine consultation at any time without affecting your right of future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled. You have the option to consult with the specialist in person if you travel to the practice location.

7. **Financial Agreement.** The telemedicine consultation will be compensated per the Payment Policy noted below:

PAYMENT POLICY

I acknowledge, understand and agree that:

1. It is my responsibility to determine whether the practice, Coia Comprehensive Primary Care, LLC services are covered by my insurer. I will pay the cost of any service that is not covered by my health plan for any reason or are covered but applied to a deductible.
2. I will pay at time of service any required co-payments, co-insurance and deductibles, as well as charges for services not covered by insurance, outstanding balances and delinquent accounts.
3. I will be billed for all unpaid balances deemed by Coia Comprehensive Primary Care, LLC or my insurer to be my responsibility and agree to pay such amounts in full.
4. I assign to the practice Coia Comprehensive Primary Care, LLC to all health care benefits to which I am entitled under any insurance policy or benefit plan and authorize payment of benefits directly to Coia Comprehensive Primary Care, LLC .

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5. If I have health care benefits, Coia Comprehensive Primary Care, LLC will submit a claim to my insurer and allow 60 days for a response. If my insurer does not respond within 60 days, Coia Comprehensive Primary Care, LLC will assume that the visit is not covered and will, to the extent permitted by law, bill me for the visit charges.
6. By providing my credit card information and receiving telehealth services, I (i) authorize Coia Comprehensive Primary Care, LLC to charge my credit card for any and all unpaid amounts that Coia Comprehensive Primary Care, LLC or my insurer determines are my responsibility, and (ii) agree to pay all amounts charged pursuant to this consent and authorization in accordance with the issuing bank cardholder agreement. I agree that Coia Comprehensive Primary Care, LLC may charge my credit card for such amounts at the end of my telehealth visit or at a later date.
7. Coia Comprehensive Primary Care, LLC reserves the right to deny non-emergency services if my account is delinquent.

I have been advised of all the potential risks, consequences and benefits of telemedicine and understand the written information provided. My health care practitioner has discussed with me the information provided above. I have had an opportunity to ask questions about this information and all of my questions have been answered.

Patient Name or Representative: _____
Please Print

Signature: _____ **Date:** _____
Patient or Representative

If signed by Representative, relationship to patient:_____

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