The Spring Center, Kelly K McCann, MD
Informed Consent for TeleHealth Consultations

Patient Name _____ DOB _____

"TeleHealth" means that you may be evaluated and treated by a health care provider from a distant location via electronic communication. The information may be used for diagnosis, therapy, follow-up, and/or education, and may include any of the following: patient medical records, medical images, live two-way audio and video, and/or output data from medical devices and sound and video files.
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 unless my insurance has agreed to make a special consideration to cover telehealth services. I also understand that I may be responsible for telehealth services if all or some of my consultation is not covered by my insurance.

Authorizations
The undersigned patient, or authorized individual acting on behalf of the patient, understands and agrees as follows:

- By signing below, I am granting permission to The Spring Center to perform and administer care and treatment of the patient via telehealth.
- Grants permission to release to third party payor(s) (such as Medicare or private insurance companies), their representatives, and/or other 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 telehealth services provided. I authorize payments directly to The Spring Center and Kelly K. McCann, MD 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 Medicare and any other private insurance company(s).

Printed Name of Signer _____

Relationship to Patient _____

Signature _____ Date _____