Telemedicine Informed Consent

Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
2. I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room.
3. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
    a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
4. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
    a. I may revoke my right at any time by contacting North Texas Infectious Diseases Associates at 214-823-2533
5. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
    a. I understand that my insurance carrier will have access to my medical records for quality review/audit.
    b. I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit.
    c. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.

7. I understand that this document will become a part of my medical record.

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand; and (3) am located in the state of Texas and will be in Texas during my telemedicine visit(s).

_____	_____
Patient/Parent/Guardian Printed Name	Patient/Parent/Guardian Signature
_____	_____
Date of Birth	Date

North Texas Infectious Diseases Consultants, PA.

Consent for Treatment

I, as a patient/legal guardian, do consent for medical treatment by North Texas Infectious Diseases Consultants' (NTIDC) physicians and physician assistants, this is inclusive of any treatment or procedure they deem medically necessary.

Authorization to Release Medical Information

This is to serve as authorization to release medical information compiled in the course of medical treatment at NTIDC to the undersigned patient. A copy of this will serve as an original.

Acknowledgement of Receiving and Reading a Copy of, "Notice of Privacy Practices" and "Patient Rights and Responsibilities"

I acknowledge receipt of NTIDC's Notice of Privacy Practices. The Notice of Privacy Practice provides detailed information about how NTIDC may use and disclose by confidential information. I understand that NTIDC reserves the right to change their privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be made available to me upon request.

Tardy and Late Cancellation Policy

In order to best serve all of our patients it may be necessary to reschedule your appointment if you are 15 minutes late or more. Failure to come in for your appointment without giving our office at least 24 hours notice may result in a $30 charge on your account.

Physician Assistant Consent for Treatment

A physician assistant is not a doctor. A physician assistant is a graduate of a certified training program and is licensed by the state board. Under the supervision of a physician, a physician assistant can diagnose, treat and monitor common acute and chronic diseases as well as provide health maintenance care. "Supervision" does not require the constant physical presence of a supervising physician, but rather overseeing the activities of and accepting responsibility for the medical services provided.

I understand that at any time I can refuse to see the physician assistant and request to see a physician.

I have read the information above and consent to all.

Print Patient Name **Date of Birth** **Patient's Signature** **Date**

PLEASE COMPLETE THE BACK OF THIS FORM

Dear Patient,
Our office is pleased to have the opportunity to serve you. Our primary mission is to provide you with quality, cost effective, medical care. Together, we (patients and physicians) are trying to adapt to the changing way that healthcare is financed and delivered. The following letter outlines some of the financial and procedural steps required by your insurance or managed care plan.

Payment Guidelines:

- We must collect any co-payments, co-insurance, and /or deductibles at the time of service, unless other arrangements have been made in advance with our office.
- We accept **Cash, Checks, Money Orders, & Credit Cards** (Visa, MasterCard, Discover and American Express).
- The remainder of your bill will be sent to your insurance company for payment to our office.
- If, by mistake, your insurance company remits this payment to you, please send it to us along with all paperwork sent to you. **Please do not send the payment back to the insurance company.**
- Any balance that your insurance company determines to be your financial responsibility will be billed to you. Payment is due in full upon receipt of your first statement.

When to Present Insurance Card?
Please present your insurance card at **EACH VISIT.** Specifically bring to our attention any changes (new card, new group #, etc.) since your last visit. This protects you from paying a bill because we had the wrong insurance information. There is a narrow window (30-45 days) to present an accurate claim to the correct insurance company. Failure to do so could mean the claim may be denied. In addition, if you have a secondary insurance, it will be filed on your behalf as a courtesy. However, if we have not received payment from your secondary insurance in a timely manner, the balance will become your responsibility.

Insurance Company Denies Payment?
Sometimes your insurance company will refuse payment of a claim for some of the following reasons:

1. This is a pre-existing illness or condition that they do not cover.
2. You have not met your full calendar year deductible.
3. The type of medical service required is not covered.
4. The insurance was not in effect at the time of service.
5. You have other insurance which must be filed first.
6. You have exceeded your maximum dollar/visit amount.
7. You did not have a referral number for your visit/service.

If your insurance company denies your claim for any of the above reasons or for any other reasons, our office cannot be responsible for this bill. It is your responsibility to pay the denied amounts in full at the time of billing.

We value you as a patient and are eager to serve you! Our first priority is to provide you with the best possible care. If you would like to contact our billing office, you may reach them at 214-276-5605.

Sincerely,
North Texas Infectious Diseases Consultants
(NTIDC)

I have read and understand my financial obligations. I understand that this office will file an insurance claim on my behalf. I assign the proceeds of such insurance claim to NTIDC. Both NTIDC and I will receive an Explanation of Benefits (EOB) from my insurance company that will detail all payments, deductions and adjustments per my plan's guidelines. NTIDC may file a claim for services rendered by the physician, facility, and/or infusion center.

I understand that I will be fully responsible for payment in full at the time of billing of any and all medical services denied by my insurance company determined to be my portion of the billed charges. Balances that remain unpaid after 90 days from the date first billed may be referred to an outside collection agency for further collection efforts.

_____ _____

Printed Patient Name **Date of Birth**

_____ _____

Patient Signature Today's Date

PLEASE COMPLETE THE BACK OF THIS FORM

Personal Information

Your Name: _____ Birthdate: _____ Date: _____

Address: _____ Apt: _____ City: _____ State: _____ Zip: _____

Marital Status: _____ Race: _____ Ethnicity: Latin/Hispanic Other Prefer not to list

Home Phone: _____ SS# _____

Fax: _____ Work Phone: _____ Cell Phone: _____

Best way to reach you: Home Cell Work

Referring Physician: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Care Physician _____ Phone: _____

Spouse: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____ hm / cell / wk

*EmergencyContact _____ Relation: _____ Phone: _____ hm /cell / wk

Patient's Employer: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

PRIMARY INSURANCE

Please circle if appropriate: HMO / PPO

Insurance: _____ Insured Name: _____

Phone: _____ Relationship: _____

Policy #: _____ Insured DOB: _____ SS#: _____

Group #: _____ Insured's Address: _____

Insured Employer: _____ _____

Employer Address: _____

SECONDARY INSURANCE

Please circle if appropriate: HMO / PPO

Insurance: _____ Insured Name: _____

Phone: _____ Relationship: _____

Policy #: _____ Insured DOB: _____ SS#: _____

Group #: _____ Insured's Address: _____

Insured Employer: _____ _____

Employer Address: _____

PLEASE COMPLETE THE BACK OF THIS FORM

NORTH TEXAS INFECTIOUS DISEASES CONSULTANTS, PA **Patient**
Consent for Use and Disclosure of Protected Health Information

North Texas Infectious Diseases Consultants, PA, (NTIDC) may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to NTIDC's Notice of Privacy Practice for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Procedures prior to signing the consent. NTIDC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the NTIDC Privacy Officer at 3409 Worth St, Suite 710, Dallas, Texas, 75246.

You may disclose protected health information (PHI) about me to the people listed below. (You must include full name.)

1._____ 2._____ 3. _____

With my consent, NTIDC may email me, any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements. I have the right to request that NTIDC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement

Email Address:_____ **N/A**

This office usues LabCorp. If your insurance requires that you use a different lab you must let the office know. My insurance prefers: (circle one)
LabCorp Quest Unknown (If unknown you must call your insurance to check)

With my consent, NTIDC may contact me regarding a possible research study.

Initials_____

How did you hear about us? _____

By signing this form, I consent to NTIDC's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance to prior consent.

_____ _____
Print Patient's Name Date of Birth Patient's Signature Date

_____ _____
Signature of Patient's Legal Guardian Print Name of Patient's Legal Guardian

Medical History

Name: _____ DOB: _____ Date: _____

Reason for today's visit:

Past Medical History
(please check all that apply)

- Blood Disorders ☐
- High Blood Pressure ☐
- Heart Disease ☐
- Lung Disease ☐
- Diabetes ☐
- Peptic Ulcer Disease ☐
- Cancer ☐
- Liver Disease ☐
- Psychiatric Disorder ☐
- Other (please list below) ☐

Prior hospital Admissions:

	Dates

Previous Surgial History:

	Dates

Past Blood Transfusions:

	Dates

Social History:

Marital Status:	☐ Married	☐ Divorced	☐ Single
Tobacco Use:	☐ Yes	☐ No	How Much? _____
Alcohol Use:	☐ Yes	☐ No	How Much? _____
Drug Use:	☐ Yes	☐ No	How Much? _____

Occupation: _____

PLEASE COMPLETE THE BACK OF THIS FORM

Patient Name:

Family History

Medical issues on your mother's side: _____

_____

_____

_____

Medical Issues on your father's side:_____

_____

_____

_____

Review of Systems (please circle all which are applicable) :

Constitutional: Weight loss Weight gain Fever Chills Sweats Fatigue Weakness

Eyes: Wear glasses Blurry vision Flashes of light Blindness

Ears, Nose, Mouth: Ear ache Poor hearing Sore throat

Cardiovascular: Chest Pain Palpitations Swelling of feet

Respiratory: Shortness of breath Cough Asthma

Gastrointestinal: Abdominal pain Nausea Vomiting Diarrhea Constipation Blood in stool

Genitourinary: Painful urination Frequent urination Nighttime urination
Problems w/testicles
Abnormal periods Last menstrual period: _____ *DATE*

Musculoskeletal: Muscle pain Joint pain

Skin: Rash Sores on skin Skin cancer Boils

Neurological: Heme/ Headache Dizziness Seizures Numbness Tingling

Lymphatic: Swollen lymph glands Anemia

Do you have other symptoms? (please list) _____

_____

_____

_____

_____

_____

Do you have a Living Will? ☐ Yes ☐ No

If "Yes", what are the contents?

☐ No Resuscitation
☐ No Feeding Tubes
☐ No Medication Support
☐ No Mechanical Ventilation
☐ Unaware of Contents
☐ Other _____

Do you have a Durable Power of Attorney? ☐ Yes ☐ No **Name:** _____

PLEASE COMPLETE THE BACK OF THIS FORM

Medication List

Name:_____ DOB:_____

Allergies (please include reaction:)_____

_____

_____

Drug Name	Dose	Route	Frequency	Prescribing MD

Signature:_____Date:_____

(Office Only) Reviewed by:_____Date:_____