TELEHEALTH CONSENT FOR MEDICAL TREATMENT AND FINANCIAL RESPONSIBILITY

1. CONSENT

I authorize my physician and other physicians who may attend me, their assistants, including those employed by Washington University Physicians in Illinois, Inc. ("WUPI"), its house staff, employees, and students to provide medical care, tests, procedures, drugs, blood and blood products, services and supplies considered advisable by my physician. These services may include pathology, radiology, emergency services and other special services ordered by my physician(s). In consenting to treatment, I have not relied on any statements as to results.

TELEHEALTH: This form obtains your consent to participate in a telemedicine consultation, also known as "Telehealth" services. Telehealth is the delivery of health care services using two-way video communications and/or the electronic exchange of information. Since this is different than in-person health care services you may typically receive, it is important for you to understand and be aware of and comfortable with the benefits and possible risks. For your Telehealth visit, a Washington University Physicians in Illinois, Inc. ("WUPI") provider will communicate using electronic and video transmissions and will have access to your medical records while you are being treated at home. This will enable your provider to determine an appropriate treatment plan for your condition. Participating in this Telehealth program will give you access to your provider without having to travel to your provider’s office, for inpatient/outpatient care.

Some possible risks associated with the use of Telehealth services include, but may not be limited to:

- Instances in which the electronic information may not be sufficient for appropriate medical decision making by the provider.

- Equipment issues, which could cause delays in your medical evaluation and treatment.

- Although rare, security measures could fail, possibly exposing your privacy and your personal medical information.

- Finally, in some cases, Telehealth services may not be as complete as in-person services, and if your provider believes an in-person visit is necessary, he or she may recommend that you schedule an in-person visit.

It is important that you understand and agree to the following statements:

1. I understand that engaging in a telemedicine visit with my health care provider at WUPI is optional. I have the right to discontinue this service at any time. I further understand that in place of telehealth services, I may request a face-to-face visit with my health care provider.

2. I have been informed and understand the alternatives to the Telehealth services that are available to me, and give my consent to proceed with Telehealth services.
3. I understand that my provider will be at a different location from me. I understand that a telemedicine visit will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as the consulting health care provider and the provider will not be able to physically examine me.

4. I understand that the video portion of the telehealth service will not be recorded.

5. I understand that others may also be present during the visit other than my health care provider and consulting health care provider(s) in order to operate the video equipment and/or facilitate the Telehealth consultation. I further understand that I will be informed of their presence in the visit and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask other personnel to leave the telemedicine examination room; and/or (3) end the visit at any time.

6. I understand that I have the right to request a copy of this informed consent and upon request it will be provided to me.

7. I understand there is a possible risk of an incomplete or ineffective visit due to technological issues, and that if any of the technological issues occur, the visit may end. The technological issues include but are not limited to: a) failure, interruption or disconnection of the audio/video connection; b) a picture that is not clear enough to meet the needs of the visit; and/or c) a minor risk of access to the visit through the interactive connection by electronic tampering.

8. I understand that my provider or I can stop the telemedicine visit if the telehealth connections are not adequate for the situation.

ACKNOWLEDGEMENT & CONSENT: I have read and understand this consent. I have been given an opportunity to ask questions and all of my questions have been answered to my satisfaction. The risks, benefits, and alternatives of the Telehealth visit have been explained to me and I hereby consent to participate in Telehealth services as described in this document during this course of treatment.

_________________________________________  ___________  ______________________________
Signature of Patient or Person Authorized to Consent   Date     Relationship to Patient

2. STORAGE AND RELEASE OF INFORMATION

I consent to the electronic storage and transmission of my protected health information. I hereby authorize my treating physician and WUPI to release by electronic means or otherwise any medical and/or billing information concerning my care, including copies of my medical records, to the following:

a. Any governmental or other entity as required by law for purposes of reporting, or for purposes of determining eligibility in government sponsored benefit programs.

b. The supplier of any blood or blood products which may be administered to me for the purposes of quality control and recipient monitoring.

c. Any continuing care, residential, or long-term care facility, or home health agency for the purposes of providing services for my care.

I understand that WUPI may release protected health information to other parties in compliance with HIPAA and Illinois law. I understand and agree that if I provide a HIPAA authorization for “all” protected health information, then WUPI may disclose its complete designated record set, including potentially sensitive information such as HIV/AIDS status or genetic testing results. I understand that if I only intend to authorize the release of certain portions of the designated record set, I must identify the portions to be released in the HIPAA authorization.

WUPI TELEHEALTH 3/20
Patient Name: ________________________________ Date of Birth: __________ Date of Service: __________

3. **MEDICARE/TRICARE INSURANCE BENEFITS**

I agree that information I gave to apply for payment is correct for any third-party payers, including Medicare or Medicaid. I authorize the release of medical or other information to the Medicare Program or its intermediaries or carriers concerning this or a related claim filed by WUPI. I request that payment of authorized benefits be made on my behalf. I understand that I am responsible for the Part B deductible for each year and/or visit, the remaining co-insurance and any other non-covered personal charges. I know I can ask for a review of my record to find out about any payments or charges I may owe if Medicare or Medicaid will not cover my charges. I know that I may receive separate bills for services provided by healthcare workers who are not employed by WUPI, such as bills for laboratory testing or imaging services requested by my physician.

I (or my representative) certify that I (or he/she) have read (or if the patient/representative is unable to read has had the form read to him/her) and understand, accept the above and further certify that I am the patient, or am duly authorized on behalf of the patient to execute such an agreement.

4. **GUARANTEE FOR PAYMENT**

In accordance with the above terms and in consideration of the services provided to the above-named patient by WUPI, the undersigned agrees, whether he/she signs as patient or guarantor, to pay WUPI, and its physicians for all services ordered by WUPI physicians, or requested by the patient/or the patient’s family. If the requirements for referral, second opinion or pre-certification of care, as outlined by my insurer, benefit plan or other payer, have not been followed, the patient and/or guarantor may in some instances be personally responsible for all charges incurred.

5. **ASSIGNMENT OF INSURANCE BENEFITS**

In consideration of any and all medical services, care, drugs, supplies, equipment and facilities furnished by WUPI, and all attending physicians, I authorize direct payment to WUPI of all insurance benefits applicable to these medical services, which are now or which shall become due and payable to me. I authorize release of my personal health information as may be required for my insurance plan to pay such benefits. I understand that I am responsible for portions of my bill not covered by insurance.

6. **HIPAA – NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

I acknowledge that I have received or I have been provided the opportunity to receive a copy of the “Notice of Privacy Practice” that explains when, where, and why my confidential health information may be used and shared. I acknowledge that WUPI, the physicians, the nurses and other WUPI staff may use and share my confidential health information with others in order to treat me, in order to arrange for payment of my bill and for issues that concern WUPI operations and responsibilities.


Initials of patient or person authorized to sign HIPAA Notice for patient __________
7. **PATIENT ATTENDED BY WUPI EMPLOYEES**
   I understand that my physician and other physicians who may attend me are doing so as employees of Washington University Physicians in Illinois, Inc. ("WUPI"), not employees or agents of Washington University School of Medicine ("WUSM") or the Washington University ("WU"). I understand that any medical treatment I receive from physicians within Illinois is provided by WUPI, not WUSM or WU. I understand WUSM and WU do not control the medical judgment of any physician attending me within Illinois. I understand that I am seeking medical care from WUPI in Illinois, not WUSM or WU.

8. **PATIENT-PHYSICIAN RELATIONSHIP**
   I understand that WUPI only consents to the creation of a patient-physician relationship as defined by applicable law. I understand WUPI does not consent to the creation of a patient-therapist relationship unless WUPI provides me with other notice stating its agreement to such a relationship. I understand that while WUPI employees may prescribe medications like antidepressants or otherwise discuss my mental health with me, these actions do not constitute consent to a patient-therapist relationship.

I have read this form, or had it read and explained to me, and had the opportunity to ask questions.

____________________________________  ______________________  
Signature of patient or person authorized to consent  Date  Patient’s relationship to person

____________________________________  ______________________  
Signature of guarantor if different than above  Date  Patient’s relationship to guarantor