Plantation Family Practice

TopLine MD Alliance

Dr. Eric Schertzer, M.D.
Patricia Luzquiños, MMS, PA-C
Mariah Dominguez, MMS, PA-C
350 N Pine Island Road, #301,
Plantation, FL 33324

Patient Information

Name:______________________________ Date of Birth:______________
First, Middle and Last name as it appears on insurance card

Sex: ❍ Male ❍ Female Social Security Number:______________________

Marital Status: ❍ Single ❍ Married ❍ Widow(er) ❍ Divorced ❍ Other:______________

Race/Ethnicity: ❍ Asian ❍ Black ❍ Hispanic ❍ Pacific Islander ❍ White ❍ Other:______________

Check one: ❍ Employed ❍ Retired ❍ Full-Time Student ❍ Other:______________

Address:______________________________

City:______________________ State:______ Zip Code:______________

Home Phone:______________________ Cell Phone:______________________

Email Address:______________________________

Employer:______________________ Phone:______________ Zip Code:__________

Referred by:______________________ Past-Primary MD:______________________

Emergency contact:______________________ Phone:______________________

Primary Insurance Information

Please provide your insurance card to the receptionist

❍ Commercial ❍ Medicaid ❍ Medicare ❍ Worker's Compensation ❍ Other:______________

Insurance Company: ______________________________

Insured/Card Holder's Name:______________________ Birthdate:______________

Relationship:______________________ Phone #:______________________

Policy #:______________________ Group #:______________________

Secondary Insurance Information

Please provide your insurance card to the receptionist

❍ Commercial ❍ Medicaid ❍ Medicare ❍ Worker's Compensation ❍ Other:______________

Insurance Company: ______________________________

Insured/Card Holder's Name:______________________ Birthdate:______________

Relationship:______________________ Phone #:______________________

Policy #:______________________ Group #:______________________

______________________________ ______________________
Patient Signature Date

Check-In By:__________

PATIENT HISTORY FORM

Name:____

Gender: ❍ M ❍ F Age:______ Date of Appointment:___________

Preferred Pharmacy Contact Information

Name of Pharmacy:______________________________ Phone #:________________

Address:____

Reason for Visit

What brings you to the office today?__________________________________

How is your general health? ❍ Excellent ❍ Good ❍ Fair ❍ Poor

Comprehensive Medical History

This important information is confidential. No one other than your healthcare provider will have access to or knowledge of this information without you express written consent. Thank you very much for taking the time to fill out this lengthy form. Completion of this history allows us to provide you the most complete medical care possible. This form will be reviewed with you during your visit.

Current Medications

What medications are you currently taking? *Please list any prescription medications, over the counter medication, vitamins, herbs or nutrition supplement that you are now taking. Please include the dosage amount and the times a day you take them.*

Name	Dosage	Frequency

Allergies

Are you allergic to any of the following? ❍ Adhesive Tape ❍ Antibiotics ❍ Aspirin ❍ Barbiturates *(for sleep)* ❍ Codeine ❍ Iodine ❍ Latex ❍ Local Anesthetics ❍ Sulfa

Do you have any other allergies?

Name	Reaction

Past Medical History *(check all that apply)*

- ❍ Alcoholism
- ❍ Allergies
- ❍ Anemia
- ❍ Anxiety Disorder
- ❍ Arthritis
- ❍ Artrial Fibrillation
- ❍ Asthma
- ❍ AIDS/HIV
- ❍ Back Problems
- ❍ Bleeding Disorder
- ❍ Blood Disease
- ❍ Blood Transfusion
- ❍ Bowel Disease
- ❍ Cancer
- ❍ COPD
- ❍ Coronary Artery Disease
- ❍ Depression
- ❍ Diabetes
- ❍ Ear Problems
- ❍ Eating Disorder
- ❍ Epilepsy
- ❍ Gerd *(reflux)*
- ❍ Glaucoma
- ❍ Gout
- ❍ Heart Disease
- ❍ Hearing Loss
- ❍ Heart Problems
- ❍ Hepatitis – A, B, or C
- ❍ High Blood Pressure
- ❍ High Cholesterol
- ❍ HIV/AIDS
- ❍ Hives
- ❍ Joint Disorder
- ❍ Kidney Disorder
- ❍ Leukemia
- ❍ Liver Disorder
- ❍ Lung Disease
- ❍ Lymphoma
- ❍ Measles
- ❍ Migraines
- ❍ Osteoporosis
- ❍ Pneumonia
- ❍ Polio
- ❍ Radiation Treatment
- ❍ Renal Disease
- ❍ Rheumatic Fever
- ❍ Stroke
- ❍ Seizures
- ❍ Skin Disorder
- ❍ Stomach Ulcer
- ❍ Substance Abuse
- ❍ Thyroid Disorder
- ❍ Tuberculosis
- ❍ Venereal Disease

Check-In By:__________

PATIENT HISTORY FORM *cont.*

Name:____

Gender: ❍ M ❍ F Age:______ Date of Appointment:__________

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Hospitalizations & Surgeries

Reason	Date

Family History *(check all that apply)*

- ❍ Alcoholism
- ❍ Allergies
- ❍ Alzheimer's
- ❍ Anemia
- ❍ Anxiety
- ❍ Arthritis
- ❍ Asthma
- ❍ AIDS/HIV
- ❍ Bleeding Disorder
- ❍ Blood Disease
- ❍ Cancer
- ❍ Diabetes
- ❍ Depression
- ❍ Epilepsy
- ❍ Genetic Disorder
- ❍ Glaucoma
- ❍ Heart Disease
- ❍ Hepatitis – A, B, or C
- ❍ High Blood Pressure
- ❍ High Cholesterol
- ❍ Joint Disorder
- ❍ Kidney Disease
- ❍ Liver Disorder
- ❍ Lung Disease
- ❍ Migraines
- ❍ Psychiatric Disorders
- ❍ Osteoporosis
- ❍ Stroke
- ❍ Substance Abuse
- ❍ Thyroid Disorder

Lifestyle Factors

Are you sexually active? ❍ Yes ❍ No # of partners in past year:______

Do you wish to be checked for STDs? ❍ Yes ❍ No

Has anyone in your home ever physically or verbally hurt you? ❍ Yes ❍ No

Have you ever smoked? ❍ Yes ❍ No # of years:______ # packs/day:______

Do you smoke now? ❍ Yes ❍ No # packs/day:______

Do you use recreational drugs? ❍ Yes ❍ No Types?____________________________ # times/week:______

How much alcohol do you drink per week? ❍ Yes ❍ No # drinks/week:______

How much caffeine do you drink per day? ❍ Yes ❍ No # drinks/day:______

How often do you exercise? ❍ Yes ❍ No # times/week:______

Check-In By:_________

PATIENT HISTORY FORM *cont.*

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Name:______________________________

Gender: ❍ M ❍ F Age:______ Date of Appointment:__________

Health Exams & Procedures *(Please check and date all immunizations you have had)*

	Mo/Yr	Result
❍ Blood Sugar-Fasting	___/___	__________
❍ Breast Self-Exam	___/___	__________
❍ Cholesterol Test	___/___	__________
❍ Colonoscopy	___/___	__________
❍ CT/CAT Scan	___/___	__________
❍ Dexascan *(Bone Density)*	___/___	__________
❍ EKG	___/___	__________
❍ Echocardiogram	___/___	__________
❍ Fecal Occult Blood Test	___/___	__________
❍ Mammogram	___/___	__________
❍ MRI	___/___	__________
❍ Pap Smear	___/___	__________

	Mo/Yr	Result
❍ Physcial Exam	___/___	__________
❍ Cardiac Stress Test	___/___	__________
❍ Ultrasound	___/___	__________
❍ Tetanus (Td) with Pretussis (Tdap)	___/___	__________
❍ Varicella *(Chicken Pox shot or disease)*	___/___	__________
❍ Pneumovax *(Pneumonia)*	___/___	__________
❍ Hepatitis A	___/___	__________
❍ Hepatitis B	___/___	__________
❍ MMR	___/___	__________
❍ Menigis	___/___	__________
❍ HPV	___/___	__________

Review of Symptoms *(check all that apply)*

ENT
- ❍ Bleeding Gums
- ❍ Blurred Vision
- ❍ Crossed Eyes
- ❍ Difficulty Swallowing
- ❍ Double Vision
- ❍ Earaches
- ❍ Ear Discharge
- ❍ Hay Fever
- ❍ Hoarseness
- ❍ Hearing Loss
- ❍ Nose-Bleeds
- ❍ Persistent Runny Nose
- ❍ Recurring Sore Throat
- ❍ Ringing in Ears
- ❍ Sinus Problems
- ❍ Vision Halos

Mental Health
- ❍ Anxiety
- ❍ Depression
- ❍ Loss of Interest
- ❍ Feeling Hopeless
- ❍ Hearing Voices
- ❍ Marital Problems
- ❍ Panic Attacks
- ❍ Trouble Concentrating
- ❍ Suicide *(Thoughts/Attempts)*

Gastrointestinal
- ❍ Appetite Gain
- ❍ Appetite Loss
- ❍ Bloating
- ❍ Bowel Changes
- ❍ Constipation
- ❍ Diarrhea
- ❍ Gas
- ❍ Hemorrhoids
- ❍ Indigestion
- ❍ Intestinal Disorder
- ❍ Lactose Intolerance
- ❍ Rectal Bleeding
- ❍ Stomach Pain
- ❍ Vomiting
- ❍ Vomittng Blood

Skin
- ❍ Acne
- ❍ Bruise Easily
- ❍ Changes in Moles
- ❍ Dry/Sensitive Skin
- ❍ Eczema
- ❍ Hives
- ❍ Itching
- ❍ Rash
- ❍ Scars
- ❍ Sores That Won't Heal

General
- ❍ Chills
- ❍ Dizziness
- ❍ Fainting
- ❍ Fever
- ❍ Hair Loss
- ❍ Hair Growth *(Excessive)*
- ❍ Night Sweats
- ❍ Sleeping Problems
- ❍ Thirst *(Excessive)*
- ❍ Weight Gain
- ❍ Weight Loss

Neurological
- ❍ Coordination Problems
- ❍ Convulsions
- ❍ Difficulty Walking
- ❍ Learning Disabilities
- ❍ Light-Headedness
- ❍ Memory Loss
- ❍ Numbness/Tingling
- ❍ Paralysis
- ❍ Seizures
- ❍ Speech Problems
- ❍ Tremors
- ❍ Other Symptoms:_____

____

____

Cardiovascular
- ❍ Chest Pains
- ❍ Irregular Heart Beat
- ❍ Circulation Problems
- ❍ Heart Palpitations
- ❍ Rapid Heartbeat
- ❍ Swelling of Ankles
- ❍ Varicose Veins

Respiratory
- ❍ Coughing
- ❍ Coughing Up Blood
- ❍ Shortness of Breath
- ❍ Wheezing

Genitourinary
- ❍ Blood Urine
- ❍ Lack of Bladder Control
- ❍ Frequent Urination
- ❍ Painful Urination

Check-In By:__________

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INSURANCE CONSENT FORM

Charges for Services Rendered

All charges for office services are due at the time of my visit to PLANTATION FAMILY PRACTICE. If an insurance claim is filed by the Practice, I request that payment of all benefits be made on my behalf to the Practice. **BY NOT SIGNING THIS AGREEMENT, SERVICES MAY BE DENIED.**

Financial Responsiblity

I understand that I am financially responsible for all charges for medical services rendered on my behalf, including those not paid or reimbursed by my insurance company. I am aware of the fact that my insurance carrier may deny payment for the services rendered. Therefore, if payment is denied, I agree to be personally liable and fully responsible for such payment.

Sharing/Disclosing Health Information

I AUTHORIZE THE Practice to share, disclose, or otherwise release medical information about me to my insurance company or any other authorized entity involved in my healthcare in accordance with the provisions of HIPAA (i.e., related to treatment, payment, or healthcare operations). I further authorize the Practice to gain access to medical records with information relevant to my treatment form any and all other healthcare providers, including but not limited to hospitals, laboratories, physicians, and others.

Treatment

I further authorize and consent PLANTATION FAMILY PRACTICE, his assistants and other Practice professional staff providing outpatient medical treatment, supplies, services, equipment and other items related to my healthcare to me as determined to be necessary in their professional judgment. I have been informed of the nature and purpose of the treatment, and potential common side effects thereof, as well as alternative treatment modalities, the approximate estimated duration of my healthcare, and that I am able to withdraw my consent for treatment either orally or in writing whether prior to or during the anticipated treatment period.

Emergency Medical Care

In the event that a life-threatening emergency occurs while I am in attendance at the Practice in which emergency medical care or treatment is required, I hereby authorize the Practice and its related providers to arrange for the care and treatment necessary to address my emergency medical condition. I further authorize the treating facility or medical personnel to provide emergency medical care and treatment and I agree to be responsible for all medical and related costs associated with such emergency and follow-up medical treatment.

Cancellation

I agree that I will provide at least twenty-four (24) hours notice to the Practice when canceling an appointment and understand that a failure to provide such notice may result in a prolonged waiting period and/or $ 35.00 cancellation fee.

Laboratory Consent

I agree and understand that any charges that my insurance may not cover will be my sole responsibility to be handled through said lab.

______________________________ ______________

Patient Signature Date

______________________________ ______________

Signature of Legal Representative Date

Check-In By:__________

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CONSENT FOR MEDICAL CARE

I, ________________________________, understand that I may have a condition that may require medical treatment. I authorize the practice of PLANTATION FAMILY PRACTICE to determine what kinds of diagnostic procedures (tests) must be done in order to learn more about my condition. These may include x-rays, blood tests, urine analysis, blood pressure tests, or other routine tests. I understand that if my doctor advises a more complex test, or one which has special risks, that it will be explained to me. Further, I authorize the personnel of the practice to assist in giving, or to give, the tests which my doctor recommends and obtain pharmacy prescription benefits and medication history.

I also authorize my doctor to determine what kind of treatment is to be given, and to perform such procedures as he/she may deem necessary in his/her professional judgment, to preserve my health. Additionally, I authorize the personnel of the practice to assist in giving, or to give, the therapy which my doctor will order. I fully understand that medical test or treatment may involve certain unavoidable risks. If part of my treatment is complex or carries special risks, it will be explained to me.

I understand that it is not practical to list every aspect of medical care, nor every procedure or treatment which I might receive. However, I acknowledge that my doctor is available to answer any questions I may have. I understand that the practice of medicine and surgery are not exact sciences, and acknowledge that no guarantee or assurance has been made to me as the results of treatments or examination.

______________________________ ______________
Patient Signature Date

______________________________ ______________
Signature of Legal Representative Date

Check-In By:__________

GENERAL CONSENT FOR COMPREHENSIVE EXAMINATIONS INVOLVING PELVIS AND/OR RECTUM

Plantation Family Practice

I understand the planned procedure and I consent to a medically indicated physical examination which may include, but may not be limited to the following:

( ) A female Gynecological Exam which may include a rectal exam and a pelvic exam.

( ) A rectal exam only.

( ) Other procedures as listed ______________________________

( ) Examination of external genitalia ______________________________

This examination will be performed by any provider from ______________________________ LLC.

The consent will remain active until I withdraw my consent in writing.

____
Name of Patient

____
Signature of Patient or Patient's Representative if under 18

____
Date

Check-In By:__________

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ADVANCED DIRECTIVES

A living will is a document that advises your family and physician of your desires should you become unable to make decisions regarding your healthcare. A healthcare surrogate is a person that you designate to make decisions on your behalf in the event that you are unable to. If you have these documents prepared already, please provide the practice with a copy to be included in your chart.

____ ____________________

Patient Signature Date

____ ____________________

Witness Signature Date

I have signed Advanced Directives ________ YES ________ NO

Check-In By:__________

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HIPAA *Effective April 09, 2003*

Please Note the Following Important Information

The practice of PLANTATION FAMILY PRACTICE is committed to maintain and protecting the confidentiality of our patients' personal and confidential information. We are required by federal and state law to protect the privacy of our patients' health and personal information. Therefore, we have instituted the following changes to ensure compliance with these laws.

The above named practice may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below. I hereby authorize said assignee to release all information necessary to secure the payment. I authorize the office of PLANTATION FAMILY PRACTICE to download my medication history and Rx benefits into my account from a Rx clearinghouse.

We are no longer permitted to leave a detailed message on an answering machine or with family members. We must speak directly to the patient.

In order for personal information to be released to any other person(s) other than the patient the following release must be filled out: **PLEASE INITIAL NEXT TO THE OPTION(S) YOU CHOOSE.**

1) I ______________________ authorize the practice of PLANTATION FAMILY PRACTICE to release my medical information and will accept responsibility for the loss of privacy. You may leave a message for me at the following number(s)

1.

2.

2) I authorize release of any and all medical information whether verbally or in writing to the following person(s)

	Name	Relationship
1.	______________________________	______________________________
2.	______________________________	______________________________

______________________________ Patient Signature

______________ Date

Check-In By:__________

OFFICE POLICIES

Plantation Family Practice
TopLine MD Alliance

1) PERSCRIPTION MEDICATIONS INCLUDING NARCOTIC MEDICATIONS WILL NOT BE CALLED IN TO PHARMACY AFTER WORKING HOURS.

2) LAB REQUISTIONS WILL EITHER BE SUPPLIEDTO PATIENT AT TIME OF VISIT OR MAILED TO THE PATIENTS ADDRESS PROVIDED.

3) LAB AND/OR TEST RESULTS WILL NOT BE AVAILABLE AFTER WORKING HOURS.

4) ALL COPIES OR OUTSTANDING BALANCES WILL BE COLLECTED BEFORE TIME OF APPOINTMENT.

5) THERE WILL BE A $35.00 FEE FOR ANY AND ALL FMLA/DISABILITY FORMS FILLED OUT BY THE DOCTOR OR OFFICE STAFF. A 35% FEE WILL BE ADDED TO ACCOUNTS IN COLLECTIONS.

6) ILLNESSES WILL NOT BE TREATED OVER THE PHONE, NOR WILL ANTIBIOTIC MEDICATIONS BE CALLED IN. PATIENTS MUST PRESENT IN OFFICE FOR APPROPRIATE MEDICAL CARE AND TREATMENT.

7) I AUTHORIZE PLANTATION FAMILY PRACTICE TO SEND AUTOMATIC ELECTRONIC COMMUNICATION VIA TEXT/EMAIL.

_______________________________ _______________
Patient Signature Date

_______________________________ _______________
Signature of Legal Representative Date

Check-In By:__________

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Telehealth Informed Consent Form

Telehealth involves the use of secure electronic communications, information technology, or other means to enable a healthcare provider at one location, and a patient in another location to share individual patient clinical information for the purpose of consulting with, diagnosing, treating, prescribing, and/or referring the patient to in-person care, as determined clinically appropriate. This "Telehealth Informed Consent" informs the patient ("patient," "you," or "your") concerning the treatment methods, risks, and limitations of using a telehealth platform.

Services provided:

*Telehealth services offered by Plantation Family Practice LLC ("**Practice**"), and the Practice's engaged providers (our "**Providers**" or your "**Provider**") may include a patient consultation, diagnosis, treatment recommendation, prescription, and/or a referral to in-person care, as determined clinically appropriate (the "**Services**"). Your Provider will be licensed in the state where you are located at the time of your consultation, or otherwise meet a professional licensure exception under applicable state law.*

Electronic transmissions:

The types of electronic transmissions that may occur using the telehealth platform include, but are not limited to:

- *Appointment scheduling*
- *Completion of medical intake forms*
- *Exchange and review of patient medical intake forms, patient health records, images, diagnostic and/or lab test results via asynchronous communications*
- *Two-way interactive audio in combination with store-and-forward communications between you and your Provider*
- *Two-way interactive audio-video interaction between you and your Provider*
- *Review and treatment recommendations by your Provider based upon output data from medical devices and sound and video files*
- *Delivery of a consultation report; and/or other electronic transmissions for the purpose of rendering clinical care to you*

Expected benefits:

- *Improved access to care by enabling you to remain in your preferred location while your Provider consults with you. Our telehealth services are available 8 hours a day, 5 days a week.*
- *Easy access for follow-up care. If you need to receive non-emergent follow-up care related to your treatment, please contact your Provider by calling the office at 954-475-4000*

Check-In By:__________

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Service limitations:

- *The primary difference between telehealth and direct in-person service delivery is the inability to have direct, physical contact with the patient. Accordingly, some clinical needs may not be appropriate for a telehealth visit and your Provider will make that determination.*
- **OUR PROVIDERS DO NOT ADDRESS MEDICAL EMERGENCIES. IF YOU BELIEVE YOU ARE EXPERIENCING A MEDICAL EMERGENCY, YOU SHOULD DIAL 9-1-1 AND/OR GO TO THE NEAREST EMERGENCY ROOM. PLEASE DO NOT ATTEMPT TO CONTACT Plantation Family Practice LLC OR YOUR PROVIDER. AFTER RECEIVING EMERGENCY HEALTHCARE TREATMENT, YOU SHOULD VISIT YOUR LOCAL PRIMARY CARE DOCTOR.**
- *If it is determined during the initial screening of the telehealth visit that you should be seen in person, either in your Provider's office or in a recommended facility, you will not be charged for the telehealth visit. Appropriate emergency questions will be asked at the beginning of the telehealth visit that will determine what will be the best place for you to receive care.*

Security measures:

The electronic communication systems we use will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption. All the Services delivered to the patient through telehealth will be delivered over a secure connection that complies with the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Possible risks:

- *Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment and technologies, or provider availability.*
- *In the event of an inability to communicate as a result of a technological or equipment failure, please contact the Practice at 954-475-4000.*
- *The quality of transmitted data may affect the quality of services provided by your Provider. Changes in the environment and test conditions could be impossible to make during delivery of telehealth services.*
- *In rare events, your Provider may determine that the transmitted information is of inadequate quality, thus necessitating a rescheduled telehealth consult or an in-person meeting with your local primary care doctor.*
- *In very rare events, security protocols could fail, causing a breach of privacy of personal medical information.*
- *In rare events, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other clinical judgment errors.*

Patient acknowledgments:

By checking the box associated with "Telehealth Informed Consent," you acknowledge that you understand and agree to the contents above and further agree with the following:

1. *I understand that if I am experiencing a medical emergency, that I will be directed to dial 9-1-1 immediately and that our Providers are not able to connect me directly to any local emergency services.*
2. *I acknowledge that I have been given an opportunity to select a provider; Or, I have elected to consult with the next available provider. I acknowledge that prior to the consultation, I have been given the provider's credentials.*

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3. *I understand there is a risk of technical failures during the telehealth encounter beyond the control of the Practice. I agree to hold harmless the Practice for delays in evaluation or for information lost due to such technical failures.*
4. *I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment. I understand that I may suspend or terminate use of the telehealth services at any time for any reason or for no reason.*
5. *I understand that alternatives to telehealth consultation, such as in-person services are available to me, and in choosing to participate in a telehealth consultation, I understand that some parts of the Services involving tests (e.g., labs or bloodwork) may be conducted by individuals at my location, or at a testing facility, at the direction of our Providers.*
6. *I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.*
7. *I understand that it is necessary to provide a complete and accurate medical history and will update my medical health records periodically, but no less than once a year.*
8. *I understand persons may be present during the consultation other than my Provider in order to operate the telehealth technologies. I further understand that I will be informed of their presence in the consultation, and their role, and thus will have the right to request the following: (1) omit specific details of my medical history/examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telehealth examination; and/or (3) terminate the consultation at any time.*
9. *I understand I have the right to object to the videotaping of the telehealth consultation.*
10. *I understand there is no guarantee that I will be treated by our Providers. Our Providers reserve the right to deny care for potential misuse of the Services or for any other reason if, in the professional judgment of our Providers, the provision of the Service is not medically or ethically appropriate.*
11. *I understand that I will not be prescribed any narcotics for pain, nor is there any guarantee that I will be given a prescription at all.*
12. *I understand that federal and state law requires health care providers to protect the privacy and the security of health information. I understand that Practice will take steps to make sure my health information is not seen by anyone who should not see it. I understand that telehealth may involve electronic communication of my personal medical information to other health practitioners engaged by Practice who may be located in other areas, including out of state.*
13. *I understand that if I participate in a consultation, that I have the right to request a copy of my medical records and/or consultation report, which will be provided to me at reasonable cost of preparation, shipping and delivery.*
14. *I understand that I may be asked if I have a primary care doctor and, if so, whether I consent to sending a copy of my medical records and/or consultation report to my primary care doctor. Upon my consent, Practice will send copy of my medical records and/or consultation report to my primary care doctor, which will be billed to me at reasonable cost of preparation, shipping and delivery.*
15. *I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes.*
16. *I understand that I may not be covered under my current health insurance plan for telehealth services.*

Check-In By:__________

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Patient Informed Consent

I have carefully read this form and fully understand its contents, including the risks and benefits of the telehealth services. I hereby give my informed consent to participate in a telehealth consultation under the terms described herein. By checking the box associated with "Telehealth Informed Consent", I acknowledge that I understand and agree with the above and hereby consent to receive Practice's telehealth services:

☐ **ACCEPT.** *By checking the Box for this "***TELEHEALTH INFORMED CONSENT***" I hereby state that I have read, understood, and agree to the terms of this document.*

____________________ *Patient's name*	____________________ *Parent/Legal guardian's name*
____________________ *Patient's signature*	____________________ *Parent/Legal guardian's name*
____________________ *Date*	____________________ *Date*