1447Medical Park Blvd., Suite 401
Wellington, FL 33414

Office 561-798-4100
Fax 561-798-4351

Isaac Halfon, M.D., F.A.C.O.G.

Obstetrics & Gynecology

WELCOME TO OUR PRACTICE!

Thank you for choosing the office of Isaac Halfon, M.D. We look forward to providing you with professional health care in a friendly and welcoming environment. This letter is designed to provide you with important information that most new patients find valuable. Please take a moment to read though this information.

YOUR FIRST VISIT

- Please arrive a few minutes prior to your scheduled appointment with the completed new patient paperwork attached.

WHAT TO BRING

- Completed New Patient Paperwork
- Your Insurance Card, if applicable
- Your Photo ID
- Referral from your Primary Care Physician, if applicable
- Method of Payment

APPOINTMENTS

- As a courtesy to other patients, please call the office as soon as possible if you are going to be late.
- If you are unable to keep your appointment, we ask that you provide notice of at least 24-hours in advance so we may offer that time to another patient.

We are looking forward to meeting you soon. Please visit our website for additional information (www.halfonmd.com).

Sincerely,

Isaac Halfon, M.D., F.A.C.O.G

IH/jm

Date ____________ *Fecha*

Patient Registration
Registración del Paciente

FOR INTERNAL USE ONLY
PATIENT NUMBER ____________

Patient Information - *Información del Paciente*

Social Security # ____________ *Numero de Seguro Social*

First Name ____________ *Primer Nombre* Middle ____________ *Segundo Nombre*

Last Name ____________ *Apellido*

Sex ____________ *Sexo* Date of Birth ____ / ____ / ____ *Fecha de Nacimiento*

Marital Status *Estado Civil* ☐ Married *Casada* ☐ Single *Soltera* ☐ Divorced *Divorciada* ☐ Widowed *Viuda*

Race/Ethnicity ____________ *Raza/Etnia*

(Check One) *Marque Uno* ☐ Employed *Empleada* ☐ Retired *Retirada* ☐ Full-Time Student *Estudiante Tiempo Completo*

☐ Other ____________ *Otro*

Employer ____________ *Empleador*

Work Phone (____) ____________ *Telefono de Trabajo*

Home Address ____________ *Direccion del Hogar*

City ____________ *Ciudad* State ____ *Estado* Zip ____ *Codigo Postal*

Email Address ____________

Home Phone (____) ____________ *Telefono del Hogar* Cell Phone (____) ____________ *Telefono Cellular*

I was referred to: ____________ by / *por* *Fui recomendado por*

☐ Friend ____________ *Amigo* ☐ Relative ____________ *Familiar*

☐ Physician ____________ *Médico* ☐ Insurance ____________ *Seguro*

☐ Reputation of the LLC's Physicians ____________ *Reputación de los Médicos del LLC*

☐ Existing Patient of the LLC ____________ *Paciente Existente de la LLC*

☐ Other ____________ *Otro*

Insurance Information - *Información del Seguro*

Please provide your insurance card to the receptionist - *Por favor entregue su tarjeta de seguro a la recepcionista*

☐ Commercial ☐ Medicaid ☐ Medicare ☐ Worker's Compensation ☐ Other ____________

Insurance company ____________ *Compañia de Seguro*

Insured / Card Holder's Name ____________ *Nombre del Asegurado* Relationship ____________ *Relación*

Policy # ____________ *Numero de Poliza* Group # ____________ *Numero de Grupo* Phone (____) ____________ *Telefono*

Secondary Insurance Information - *Información del Seguro Secundario*

☐ Commercial ☐ Medicaid ☐ Medicare ☐ Worker's Compensation ☐ Other ____________

Insurance company ____________ *Compañia de Seguro*

Insured / Card Holder's Name ____________ *Nombre del Asegurado* Relationship ____________ *Relación*

Policy # ____________ *Numero de Poliza* Group # ____________ *Numero de Grupo* Phone (____) ____________ *Telefono*

Emergency Contact - *En Emergencias, contactar a:*

Social Security # ____________ *Numero de Seguro Social*

First Name ____________ *Primer Nombre* Middle ____________ *Segundo Nombre*

Last Name ____________ *Apellido*

Sex ____________ *Sexo*

Home Phone (____) ____________ *Telefono del Hogar*

Work Phone (____) ____________ *Telefono del Trabajo*

Pharmacy - *Farmacia*

Pharmacy ____________ *Farmacia*

Pharmacy Phone ____________ *Numero de telefono de la farmacia*

Pharmacy Address ____________ *Direccion de la farmacia*

Spouse / Guarantor / Responsible Party - *Esposo / Persona Responsable*

Social Security # ____________ *Numero de Seguro Social*

Relationship ____________ *Relación*

First Name ____________ *Primer Nombre* Middle ____________ *Segundo Nombre*

Last Name ____________ *Apellido*

Address ____________ *Direccion*

City ____________ *Ciudad* State ____ *Estado* Zip ____ *Codigo Postal*

Sex ____________ *Sexo* Date of Birth ____ / ____ / ____ *Fecha de Nacimiento*

Daytime Phone (____) ____________ *Teléfono durante el dia*

Employer ____________ *Empleo*

Address ____________ *Direccion*

City ____________ *Ciudad* State ____ *Estado* Zip ____ *Codigo Postal*

FEES AND INSURANCE INFORMATION

All fees are payable at the time services are rendered. We accept most major credit cards. Your medical insurance is a contract between you and your insurance carrier and the terms of the contract vary according to the terms of the policy. Final payment for all charges is the patient's responsibility and should it be necessary for this account to be turned over to either an attorney or collection agency for collection, I understand that I will be liable for any charges incurred, including attorney's fees and court costs.

Todos los honorarios por servicio deben ser pagados al recibir el servicio. Aceptamos ciertas tarjetas de credito. Su seguro medico es un contrato entre usted y su compañia de seguro. Pagos por nuestros servicios dependen de los terminos de su poliza. El pago final de todos los cargos es su responsabilidad. Si es necesario tomar accion legal para cobrar esta deuda, usted es responsable de los gastos legales.

We have elected not to carry Medical Malpractice insurance or otherwise demonstrate financial responsibility. However, we agree to satisfy any adverse judgements up to the minimum amounts pursuant to S.458.320 (5) (g). Florida Law imposes penalties against non-insured physicians who fail to satisfy adverse judgements arising from claims of medical malpractice. This notice is pursuant to Florida law.

Hemos elegido no llevar seguro de negligencia medica o no demostrar de otra manera responsabilidad financiera. Sin embargo, acordamos satisfacer cualquier juicio adverso hasta las cantidades minimas conforme a S.458.320 (la ley 5) (g). Florida impone penas contra los medicos de los no-asegurado que no pueden satisfacer los juicios adversos que se presentan de demandas de la negligencia medica. Este aviso esta conforme a la ley de la Florida.

PHYSICIAN'S RELEASE AND ASSIGNMENT

I hereby authorize payment directly to the physician of all benefits applicable and otherwise payable to me from my insurance carrier, HMO or other third party payor, for services rendered by the physician. I understand that I am financially responsible to the physician for any and all charges that the carrier declines to pay. I hereby authorize the release of my medical records as deemed necessary for payment of insurance benefits.

Por la presente autorizo el pago directamente a el medico todos los beneficios derivados del seguro que ampara al paciente y que normalmente yo tendria derecho de percibir. Con mi firma autorizo transferir documentos relacionados a mi tratamiento medico a mi compañia de seguro para procesar mi reclamacion. Yo entiendo que soy responsable por todos los cargos no cubiertos bajo mi seguro medico.

PATIENT'S / GUARANTOR'S SIGNATURE _______________ DATE _______________

FINANCIAL ARRANGEMENTS AND MEDICAL INSURANCE

We are committed to providing you with the best possible care. If you have medical insurance, we want to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Payment for services is due at the time services are rendered. We accept cash, checks, MasterCard, Visa, American Express and Discover. We will be happy to help you process your insurance claim form for your reimbursement. Any such request must be accompanied by a completed insurance form at each visit. In special instances, we may accept assignment of insurance benefits.

There will be a $50.00 charge or 5% of the check amount, whichever is greater, added to your account balance for checks returned unpaid by your bank. In addition, interest will be accrued for balances over 30 days at 18% per annum and a 35% collection fee added to account balances over 90 days.

Charges may also be assessed to your account for missed appointments and appointments cancelled without 24-hours advance notice.

We will gladly discuss your proposed treatment and answer questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
2. Our fees fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50%, or 80%) of "U.C.R." "U.C.R." is defined as usual, customary, and reasonable fees for this region. Thus, our fees are considered usual, customary, and reasonable by most companies. This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.
3. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

We must emphasize that as medical care providers, our relationship is with you, not your insurance company. All charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact the Office Manager promptly for assistance in the management of your account.

For our HMO patients: **Your insurance carrier requires you to have a referral for every visit to Dr. Halfon. (Some do allow one well woman check up per year without a referral.) It is <u>your</u> responsibility to obtain your referral prior to your visit with Dr. Halfon. If you do not have your referral, your visit will have to be rescheduled (delaying your treatment and care.)**

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE do not hesitate to ask us. We are here to help you.

ASSIGNMENT OF BENEFITS

I hereby instruct and direct __________________________ Insurance Company to pay by check made out and mailed to:

Isaac Halfon MD FACOG 1447 Medical Park Blvd, Suite 401, Wellington, FL 33414

or

If my current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows:

Isaac Halfon MD FACOG 1447 Medical Park Blvd, Suite 401, Wellington, FL 33414

for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

- A photocopy of this assignment shall be considered as effective and valid as the original.
- I authorize Isaac Halfon M.D., to deposit checks received on my account.
- I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.
- I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

If appointments are NOT cancelled in advance, a $25.00 charge will be applied to your account.

Dated at Wellington, FL on ________/________/20________

____

Signature of Policyholder

____

Signature of Claimant if other than Policyholder

Notice of Privacy Acknowledgement

Isaac Halfon, M.D., LLC

I understand under the Health Insurance Portability and Accountability Act (HIPPA), I have certain rights to privacy regarding my protected health information. I acknowledge I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand this practice has the right to change its Notice of Privacy Practices and I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

______________________________ ____/____/20____

Patient Name of Legal Guardian (print) Date

____

Signature

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of Notice of Privacy Practices:

Date: ____/____/20____ Attempt: ______________________________

Staff Name: ______________________________

MALPRACTICE INSURANCE NOTICE

Dear Patients,

By law, all physicians practicing in the state of Florida must notify their patients if they do NOT carry malpractice insurance. The malpractice insurance for Obstetricians and Gynecologist is not affordable and difficult to obtain. For this reason, myself and most other Obstetricians and Gynecologist in this state, have chosen NOT to carry malpractice insurance. I will provide you with the highest quality of medical care. Thank you for choosing our office for your medical needs.

Below is a copy of the official state statute S.458.320(5)(g)5 posted in the office:

"Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law"

Thank you.

Isaac Halfon, M.D., F.A.C.O.G.

I, ______________________________ (print name) have read and understood the above Malpractice Insurance notice

______________________________(please sign your name and date)

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Isaac Halfon, M.D., F.A.C.O.G.

Obstetrics & Gynecology

Authorization to Release Information to Family Members

Many of our patients allow family members, such as their spouse, significant other, parents or children to call and request results of test, procedures and financial information. Under the requirements for H.I.P.A.A., we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results, and/or financial information released to any family member, you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize the office of Isaac Halfon, M.D., to release my records and any information to the following individuals,

1. ______________________________ Relation to Patient: ____________

2. ______________________________ Relation to Patient: ____________

3. ______________________________ Relation to Patient: ____________

4. ______________________________ Relation to Patient: ____________

5. ______________________________ Relation to Patient: ____________

______________________________ ______________________________
Patient Name (Print) Patient Signature

_____/_____/20_____
Today's Date

Patient Name: ______________________

Reason for visit (Please be brief): ______________________

List your current medications:

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

Please mark if you have any of the following:

□ High Blood Pressure □ Diabetes □ Asthma □ Arthritis □ Fibromyalgia □ Liver Disease

Do you have any illness(es) not listed? ______________________

Please list any allergies to medications ______________________

GYN History

Number of Total Pregnancies = ______________________

Number of Living Children = ______________________

Number of Abortions = ______________________

When was your last menstrual period? ______________________

When did you become menopausal? ______________________

Are you sexually active? ______________________

What is your method of contraception? ______________________

Do you smoke?	□ Yes	□ No	If yes, how many cigarettes per day? ______
Do you drink alcohol?	□ Yes	□ No	If yes, how many drinks per day? ______
Do you use drugs?	□ Yes	□ No	If yes, please list ______

Review of Systems - Please mark if you currently have any of the following symptoms

□ Fever	□ Hay Fever	□ Vaginal Discharge	□ Diarrhea
□ Chills	□ Drug Allergies	□ Pain During Sex	□ Anemia
□ Weight Gain	□ Ear Infection	□ Excessive Thirst	□ Swollen Glands
□ Nipple Discharge	□ Sore Thoat	□ Too Hot/Too Cold	□ Blood Clotting Issue
□ Skin Rash	□ Sinus Problem	□ Tired/Sluggish	□ Chest Pain
□ Blurred Vision	□ Seizure	□ Asthma	□ High Blood Pressure
□ Double Vision	□ Numbness/Tingling	□ Cough	□ Palpitations
□ Vision Loss	□ Headaches	□ Short of Breath	□ Anxiety
□ Joint Pain	□ Blood in Urine	□ Abdominal Pain	□ Depression
□ Joint Swelling	□ Painful Urine	□ Nausea	□ Suicidal Thoughts
□ Infections	□ Heavy Menstruation	□ Vomiting	

List all surgeries you have had in your lifetime (including any cosmetic surgeries):

____

Family History - List medical illnesses (Hypertension, Diabetes, Cancer [Cervical, Uterine, Ovarian or Breast] etc.):

Mother ______________________

Father ______________________

Aunt/Uncle ______________________

Sister/Brother ______________________

Isaac Halfon, M.D., F.A.C.O.G.
Self Medical History

Today's Date: ____/_____/____

Last Name: ______________________ First Name: ________________ DOB: ____/_____/____ Age: _______

PAST MEDICAL HISTORY - Do you have any of the following? Check all that apply.

___ High Blood Pressure
___ Heart Disease
___ Blurred Vision
___ High Cholesterol
___ Dizzy Spells
___ Mononucleosis
___ Accidental Loss of Urine
___ Kidney/Bladder Disease
___ Gallbladder Disease
___Hepatitis/Liver Disease
___ Thyroid Disease
___ Varicose Veins
___Difficulty Breathing
___Migraines
___Severe Headaches
___ Other ____

___Epilepsy/Seizures
___ Wt Gain >10 lbs
___Wt Loss >10 lbs
___Nose Bleeds
___Skin Condition
___Breast Lumps
___Fevers or Hot Flushes
___Abnormal Pap Smears
___ Pelvic Infections
___ Uterine Fibroids
___Vaginal Itch
___Vaginal Discharge
___Pelvic Pain
___Genital Warts
___Gonorrhea

___Herpes
___Chlamydia
___Othr Sexually Transmitted Disease
___Cough
___Constipation
___Diarrhea
___Stroke
___Cancer
___Diabetes
___Blood Clots
___Anemia
___Depression
___Heartburn

SURGICAL HISTORY – Please list all surgeries you have had in your lifetime (including any cosmetic surgery)

____
____
____

FAMILY HISTORY – Please list family members and any illnesses

Father	__ Alive	__Deceased	Illness______________
Mother	__ Alive	__Deceased	Illness ______________
Sibling	__ Alive	__Deceased	Illness ______________
Sibling	__ Alive	__Deceased	Illness ______________
Sibling	__ Alive	__Deceased	Illness ______________
Maternal Grandmthr	__ Alive	__Deceased	Illness________
Maternal Grandfthr	__ Alive	__Deceased	Illness________
Paternal Grandmthr	__ Alive	__Deceased	Illness________
Paternal Grandfthr	__ Alive	__Deceased	Illness________
Other ________________________			

Have any member(s) of your family had uterine cancer, breast cancer or colon cancer? ______________________

OB/GYNECOLOGICAL HISTORY

Do you have children? ___ Yes ___ No How many biological children? __________
Have you had any spontaneous abortions? ___ Yes ___ No How many? ____________
Have you had any abortions? ___ Yes ___ No How many? ____________

SOCIAL HISTORY

Are you ___Single ___Married ___Divorced ___Widowed
Alcohol Use ___None ___Daily ___Weekly ___Social/Holiday
Smoker? ___Yes ___ No
Drugs (Marijuana or Other) ___Yes ___No

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NEW STATE LAW EFFECTIVE JULY 1, 2020

Gov. DeSantis recently signed into law a requirement that women must consent, in writing, to a pelvic examination prior to being examined.

Therefore, beginning on July 1st 2020, we will be asking all patients to sign a consent for a pelvic examination every time they have an exam or procedure.

We apologize for any inconvenience, but this is a requirement of the law in the State of Florida and we must abide by this new legislation.

GENERAL CONSENT FOR COMPREHENSIVE EXAMINATIONS INVOLVING PELVIS AND/OR RECTUM

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:

(X) A female Gynecological Exam which may include a rectal exam and/or a pelvic exam
(X) Other procedures as listed ______________________________
(X) Examination of external genitalia
(X) An Ultrasound Exam which may include a probe placed in the vagina
(X) Pelvic Floor Therapy which may include a probe placed in the vagina and/or rectum

This examination will be performed by any provider in the office of Isaac Halfon, M.D., LLC.

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

____
Print Patient Name or Patient's Representative if under 18

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

Date ______________

Isaac Halfon, M.D.

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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 Isaac Halfon, M.D, LLC, 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. Please call our office directly to schedule your telehealth appointment.
- 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 our office directly at 561-798-4100.

TopLine MD Alliance

1447 Medical Park Boulevard – Suite 401
Wellington, FL 33414

- More efficient care evaluation and management. You may request a telemedicine appointment and should receive a response within 24 hours. We will try our best to schedule your appointment by the end of the requested date.

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 DR. HALFON, M.D., 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 561-798-4100.
- 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.

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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.
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.

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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.

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

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Alliance