PURPOSE:

The purpose of this form is to obtain your consent for a telehealth visit with dermatologists at Dawes Fretzin Dermatology Group. The purpose of this visit is to help in the care or your skin problem.

TELEHEALTH SPECIFIC FINANCIAL RESPONSIBILITY STATEMENT:

Telehealth is a new service, and as such we cannot guarantee coverage by all insurance policies. All Telehealth patients MUST provide a credit card to be on file for copays, deductibles, and flat rate payments. If you provide current insurance information, we will attempt to bill insurance for your services, and your copay will be due at time of scheduling. If the claim is accepted, you will be responsible for any copay, coinsurance, or deductible that your insurance provider allows (like an in-person office visit.) Final patient responsibility will be determined if/when charges are processed by your insurance. We can provide you with any documentation needed to submit the claim to your insurance provider (if denied) yourself upon request. Should valid insurance be provided to the office after the date of service and denied for timely filing, patient will be responsible for the full balance due. A $25.00 fee will be assessed for returned checks. A fee of $25.00 will be charged for all appointments missed or cancelled with less than 24 hours' notice.

The undersigned acknowledges that in the event this account is turned over to collection, I will be responsible for the costs of collection, which includes, but is not limited to, reasonable collection agency fees equal to 33% of the delinquent balance, reasonable attorney's fees, court costs, witness costs and prejudgment interest at 8% per annum. Each party further agrees that the Marion County Circuit, Superior, or Small Claims Court shall be the proper court of jurisdiction and venue. Further, each party waives trial by jury.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN, RELEASE INFORMATION, AND PRIVACY:

I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services. I also authorize the Physician to release any information acquired during my treatment necessary to process insurance claims. All federal and state laws covering access to your medical records also apply to Telehealth. All information given at your Telehealth visit will be maintained according to our standard practices and will be protected by federal and state privacy laws

CONSENT TO TREAT:

I request and give consent to my physician to provide and perform such medical services as are considered necessary or beneficial by my physician for my health, and well-being. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me. I understand and I agree that I solely assume the risk of any errors or deficiencies in the electronic transmission of information during my telehealth visit or in the electronic submission of images to the office. To the extent permitted by law, I agree to waive and release my dermatologist and Dawes Fretzin Dermatology Group from any claims I may have about this advice or the Telehealth visit generally. The consent provided in this document will expire one year from the date of your verbal acknowledgement, but the waiver and release shall apply indefinitely for any Telehealth visits that occur during the one-year period post documented acknowledgement. I consent that I am physically in Indiana at the time of this telehealth visit.

RELEASE OF PROTECTED HEALTH CARE INFORMATION VIA TELEPHONE TO ANSWERING MACHINE OR VOICEMAIL:

I give consent and authorization for the Medical or Billing Staff of my Physician's office to leave Protected Health Information about me or for me on my answering machine or voicemail via the telephone number I have listed. I understand I may revoke this privilege at any time by submitting my request in writing to this office.

I verbally acknowledge a receipt of a copy of Notice of Privacy Practices

Date **(office use)** ____________________________

Verbal consent witness **(office use):** _________________________________ **Account# (office use)** _______________