HealthLinkNow

Patient Consent for a Telemedicine Encounter

1. I hereby consent to take part in a **Telemedicine visit** delivered through secure video with the health care provider located at a distant location. I understand that I will be informed if any additional personnel are to be present at any time during the visit and that I have the right to refuse or stop participation in the telemedicine visit at any time.
2. By signing this consent form, I give HealthLinkNow permission to collect, and give my pharmacy, health provider and/or plan permission to disclose, information about my **prescriptions** that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health conditions, such as depression. This information will become part of my medical record.
3. I understand that I have certain rights to privacy regarding my **protected health information**, which will be used to a) conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly, b) obtain payment from third-party payers and c) conduct quality assessments and physician certifications. The HealthLinkNow Notice of Privacy, which may be updated periodically, is posted at www.HealthLinkNow.com.
4. I hereby authorize HealthLinkNow to upload, release or disclose all information of any kind on file and/or in the HealthLinkNow electronic health record "AthenaHealth" concerning "me" including, but no limited to, summary of health information, entire record, therapy notes, consultations, progress notes, nurses' notes, medication records, and treatment plans to my primary care physician, other referring physician or health plan. I understand the information to be released or disclosed may include information relating to behavioral health, sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), and alcohol/drug abuse. I authorize the release and disclosure of this type of information. It is highly recommended that you register with the Athena patient portal for access to your medical team and to receive appointment reminders.
5. I understand that I may refuse to sign this authorization or revoke this at any time. Participation in these services will serve as your acknowledgment and consent to this agreement.
6. I have the right to access my treatment records. I further understand that if the person or entity that receives the above-specified information is not a health care provider, health plan, or health care clearinghouse covered by the federal privacy regulations or a business associate of these entities, the information provided above may be re-disclosed and no longer protected by regulations.
7. I am financially responsible for all charges that occur in the course of the authorized treatment. I hereby authorize that payment of insurance benefits, from Medicare, Medicaid, worker's compensation, private insurance, and/or any other health/medical plan, be issued directly to HealthLinkNow, for any healthcare services rendered to myself and/or my dependents by HealthLinkNow. I understand that I am financially responsible for any charges not covered by my health care benefits. I understand that it is my responsibility to report to HealthLinkNow any changes in my insurance coverage. I authorize HealthLinkNow to release any pertinent healthcare information necessary to insurance carriers to obtain these benefits. HealthLinkNow may also process insurance claims generated in the course of examination and treatment. An electronic signature of this may be used as permission to process insurance claims. This order will remain in effect until revoked by me in writing.
8. HealthLinkNow's No Show Policy and Fees:
   - "No Show" is defined as appointments cancelled less than 24 hours in advance. Time limits for late appointments are:
     - **Initial appointments and 60-minute sessions** are considered a "No Show" **10-minutes** after the scheduled time.
     - **Follow up appointments (30-minutes)** are considered a "No Show" **5-minutes** after the scheduled time.
   - "No Show" Fees:
     Psychiatry Appointments:
     - Missed **Initial Appointments** will result in a $100.00 "NO SHOW" fee.
     - Missed **Follow-Up Appointments** will result in a $50.00 "NO SHOW" fee.

     Clinician Appointments:
     - Missed Initial and Follow-Up Appointments will result in a $100.00 "NO SHOW" fee.
9. Decision to treat and prescribe is at the discretion of the provider.
10. An eSignature on this document will be considered a valid form of authorization.

I consent to participating in the telemedicine encounter as described above.

Signature of patient or legal guardian: _____ Date: _____ Time: _____

Full name of Patient (PRINTED): _____ Date of Birth: _____