HILLSIDE
MEDICAL GROUP

Telehealth Consent Form

By signing this form, I understand and agree that Telehealth/Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. In addition to myself, members of my health care team, my family members, or my other legal representatives/guardians may join and participate on the telehealth/telemedicine services, and I agree to share my personal health information with such family members, caregivers, legal representatives or guardians. The information may be used for diagnosis, therapy, follow-up and/or education.

1. I hereby authorize Hillside Primary Care, PLLC, dba; Hillside Medical Group and all of its other dba's to use the telehealth practice platform for telecommunication to provide the evaluation, testing and diagnosing of my medical condition(s).

2. I understand that technical difficulties may occur before or during the telehealth sessions and my appointment may not be started or ended as intended. Disruption of signals or problems with the internet may cause broadcast or reception problems that may prevent effective interaction between the consulting clinician, patient and the healthcare team. As with any internet based communication, I understand that there is a risk for security breaches.

3. I accept that the professionals can conduct interactive sessions with video call; however, I am informed that the sessions can also be conducted via regular voice communication (i.e. phone) if the technical requirements such as internet speed cannot be met.

4. I understand that my current insurance may not cover the additional fees of the telehealth practices and that I will be responsible for any fee that my insurance company does not cover.

5. I agree that my medical records from telehealth services can be kept for further evaluation, analysis and documentation, and in all of these, my information will be kept private.

6. I understand that I have the right to withhold or withdraw consent to the use of telehealth/telemedicine services at any time and revert back to traditional in-person clinic services. I have read, understand and agree to above with the requirements.

Name: _____

Date: _____

Signature: _____

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Patient Financial Responsibility

Thank you for choosing us as your healthcare provider. We are committed to the success of your treatment. Please understand that payment of your bill is considered a part of the treatment process. The following is a statement of our "Financial Policy" which we require that you read and sign prior to our rendering any service or treatment is rendered.

Payment in Full is Due At The Time Of Service Unless Prior Arrangements Are Made. We Accept Cash, Visa, Master Card.

Insurance Participation

We may accept assignment of benefits from designated insurance carriers. However, we do require that the estimated copayments and Deductibles be paid at the time of service. The balance is your responsibility whether your insurance pays or not. We cannot bill your insurance company unless you provide current and accurate insurance information. Our office will require copies of the front and back of your insurance Cards. Blood lab fee will be charged to your insurance company but in the event of non coverage test, you will be responsible to pay for tests. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract unless you are insured by a plan with which we participate and have signed an agreement. If your insurance company has not paid your account in full within 60 days, the balance due will be automatically transferred to your account. Please be aware that some, and perhaps all of the services provided to you may be considered non-covered or not reasonable and necessary under the policies of your medical insurance carrier or Medicare. In the event that your insurance coverage changes to a plan with which we do not participate, we will require assignment of benefits to our office or full payment will be due according to the payment arrangements.

Please note again that balance is your responsibility. We will mail 3 statements on a monthly basis. If the balance due is not paid in full after 3 statements, the patient consents to charging their credit card on the file. Patient may clarify any billing questions by calling us or sending us a email at **office@hillsidemedicalgroup.com**

Patient consents to Email, text and voice reminders and messaging. Patient gives consent to retrieve prescription history when the request is triggered.

Missed Appointments

Please help us serve you better by keeping scheduled appointments. Unless canceled, at least 24 hours in advance, our policy is to charge $50.00 fee for appointments not canceled 24 hours in advance. You can Call us/Leave a voicemail or Email us at **office@hillsidemedicalgroup.com** to cancel your appointment in advance. NO SHOW FEE is non refundable and will be charged automatically on the day of NO SHOW using the Credit card that is given on file.

Thank you in advance for your understanding of our Financial Policy. Please let us know if you have any questions or concerns.

Name: _____

Date: _____

Signature: _____

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CONSENT FOR TREATMENT

General Consent to Treat

I voluntarily consent to treatment and/or related services by Hillside Primary Care, PLLC, dba; Hillside Medical Group and all of its other dba's which may be advised and recommended by the provider. I understand that in the event of a medical or psychiatric emergency which may be life threatening, that it may become necessary for Hillside Primary Care, PLLC, dba; Hillside Medical Group and all of its other dba's to render such emergency treatment and/or transfer myself or my child to a hospital for treatment.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this organization.

I am aware that I may stop my treatment with Hillside Primary Care, PLLC, dba; Hillside Medical Group and all of its other dba's at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court).

I am aware that an agent of my insurance company or other third-party payer may be given information about the type(s), cost(s), date(s) and providers of any services or treatments I receive. I understand that if payment for the services I receive here is not made, Hillside Primary Care, PLLC, dba; Hillside Medical Group and all of its other dba's may stop treatment.

I acknowledge that I have received a copy of Hillside Primary Care, PLLC, dba; Hillside Medical Group and all of its other dba's Notice of Privacy Practices which summarizes the ways my health information may be used and disclosed by Hillside Primary Care, PLLC, dba; Hillside Medical Group and all of its other dba's and states my rights with respect to my Protected Health Information (PHI). I understand that Hillside Primary Care, PLLC, dba; Hillside Medical Group and all of its other dba's has the right to revise these information practices and to amend the Notice of Privacy Practices. I have been informed that in the event Hillside Primary Care, PLLC, dba; Hillside Medical Group and all of its other dba's changes this Notice, a revised Notice will be posted in the office waiting area and that I may obtain a current Notice of Privacy Practices at any time from the front desk.

Name: _____

Date: _____

Signature: _____