Printed Name_____**Date of Birth**_____

Please agree to the below consent form prior to your Telemedicine/Virtual Clinic consultation

Informed Consent for Telemedicine/Virtual Clinic Consultations

"Virtual Clinic" means that you may be evaluated and treated by a health care provider or specialist from a distant location via electronic communication. Since this may be different than the type of consultation with which you are familiar, it is important you understand and agree to the following statements:

- The consulting health care provider will be at a different location from me. Additional medical or registration personnel may also be present in the room with the Provider.
- I understand that my voice and image may be recorded in order to assist the medical or registration personnel and I consent to any such audio and video recording.
- I understand there are potential risks to this technology, including, but not limited to, interruptions, unauthorized access, technical difficulties, and call termination. I understand there are alternatives and limitations to this type of care. I understand that my health care provider or I can discontinue the telemedicine consultation/visit if it is felt that the videoconferencing connections are not adequate for my situation.
- I understand that I may be released before all my medical problems are known or treated and it is my responsibility to make such conditions or symptoms known to the medical personnel as well as to make arrangements for follow-up care.

Authorizations

- The undersigned patient, or authorized individual acting on behalf of the patient, understands and agrees as follows: By signing my name below, I am granting permission to all physicians, therapist, laboratories, and any other professionals to perform and administer care and treatment of the patient, or designated other qualified health care provider for such services.
- Grants permission to release to third party payor(s), Medicare, Medicaid, their representatives and/or physician(s) involved in the patient's care, any information needed in connection with all care rendered to patient.
- If the patient is under the age of 18 or lacks capacity, the signing party affirms that they are either the parent or legal guardian of such patient and has full legal authority to seek medical assistance on behalf of the patient.

Financial Responsibility

I and/or my insurance carrier(s) agree to pay, in a timely manner, for health care services provided. I authorize payments directly to Lenzmeier Family Medicine for all benefits payable. I understand that some private and government insurers do not include coverage for this service as a "Covered Service". I understand that I am responsible for any unpaid bills not covered by Medicare and/or any other private insurance company(s).

Signature_____**Date**_____

Patient Guardian

(if applicable)_____**Date**_____

please mail to Lenzmeier Family Medicine 20100 N 51st Ave., F630 Glendale, AZ 85308

or fax to 623-376-8040