United Telehealth Corp
7975 North Hayden Road Suite D-354
Scottsdale, AZ 85258
Phone: 480.268.2670 - Fax: 480.268.2671

Patient Name: _____

PATIENT RELEASE AND CONSENT

- ❑ I understand that telemedicine is the use of electronic information and communication technologies by a healthcare provider used to deliver services to an individual when he/she is located at a different location or site than I am.
- ❑ I understand that the laws that protect privacy and the confidentiality of medical information including (HIPPA) also apply to telemedicine.
- ❑ I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without effecting my right to future care or treatment.
- ❑ I understand that by signing this form that I am consenting to receive health care services via telemedicine.
- ❑ I hereby authorize United Telehealth Corp to directly bill Medicare or Medicaid (AHCCCS), and for my insurance company to make direct payments to United Telehealth Corp.
- ❑ United Telehealth Corp may obtain medical or other information necessary in order to process my claim(s), including determining eligibility and seeking reimbursement for medical supplies ordered.
- ❑ I am aware the Medicare may not pay for preventative medicine, routine physical, or screening test.
- ❑ I am aware that I am responsible for any deductible, co-payment or any amount that is not covered by my insurance company for my telemedicine visit. I understand all health plans are not the same, and they do not always cover the same services. In the event my health plan determines a service to be “not covered” I will be fully financially responsible for the complete charge(s).
- ❑ I hereby authorize United Telehealth Corp to release any information necessary to insurance carriers regarding by illness and treatments.
- ❑ I hereby authorize a copy of my insurance card and any other identification to be used to process insurance claims for the period of my lifetime, this authorization will remain in effect until revoked by me in writing.
- ❑ I hereby authorize United Telehealth Corp to obtain any and all medical records that pertain to my health care and/or any pertinent Protected Health Information.
- ❑ If I miss two consecutives visits, I may become ineligible for further services.
- ❑ I acknowledge receipt and have read and understand the Notice of Health Information Practices regarding my provider’s participation in the statewide Health Information Exchange (HIE), or I previously received this information and decline another copy. { Reconozco que recibí y leí el Aviso de Prácticas de Información de Salud. Entiendo que mi proveedor de salud participa en Health Current, el intercambio de información sobre la salud de Arizona (HIE – por sus siglas en inglés)}

Patient name: _____

Signature: _____

Relationship to patient (If other than patient): _____

Date: _____

Please note new patients must fill out all forms completely before our initial home visit.