Osceola Medical Center

2600 65th Ave

OSCEOLA, WI 54020-0218

Phone: (715)294-2111, Fax: (715) 294-1990

Telemedicine/Telehealth/Secure Online Video Appointment Consent Form

Consent for Treatment: I consent to telehealth/telemedicine care performed by my physician and all other associated health care providers at Osceola Medical Center. This includes examinations, diagnostic testing, treatment and other health care services deemed medically necessary in the Providers' professional judgment. I understand that the practice of medicine is not an exact science and that diagnosis and treatment may cause injury or even death. I also understand that I have the option to refuse the delivery of health care services by telehealth/telemedicine at any time without affecting my right to future care or treatment, and without risking the loss or withdrawal of any benefits to which I would otherwise be entitled. If I am pregnant, this consent also applies to my fetus.

Consent for Telehealth/Telemedicine Services: Telehealth/Telemedicine involves transmission of video, photographs, and/or details of my medical record such as x-rays and test results (collectively "Data"). All Data is sent by secure electronic means to the Providers to facilitate the medical service being performed. I understand that: • I will be informed of any other people who are present at either end of the telehealth/telemedicine encounter, and have the right to exclude anyone from either location. • All confidentiality protections required by law or regulation will apply to my care. • I have the right to refuse or stop participation in telehealth/telemedicine services at any time and request alternative services such as an in-person appointment. However, I understand that the equivalent in-person services might not be available at the same location as the telehealth/telemedicine services. • If I do not want to receive health care services by telehealth/telemedicine, it will not affect my right to future care or treatment, or any insurance/program benefits to which I would otherwise be entitled. • If an emergency occurs during a telehealth/telemedicine encounter, 911 will be called and your Provider will stay on the video until help arrives.

Records and Release of Information: Transmitted Data may become part of my medical record. Data will not be transmitted to people outside of my health care team except as described below, and/or if I provide additional consent. • I will have access to all of the information in my medical record resulting from the telehealth/telemedicine services that I would have for a similar in-person visit, as provided by federal and state law. • The Provider may use or disclose my health information for treatment, continuity of care, payment, or internal operations, or when required by law or regulation in certain unique situations. • All releases of information are subject to the same laws and regulations as in-person care.

Payment Agreement/ Assignment of Benefits: I agree to be responsible for any co-payments, deductibles, or other charges from the Providers and their providers that are not covered or paid by insurance or their third party payors—except as prohibited by any state or federal law, or any

agreement between my insurance company and the Providers of Osceola Medical Center. I authorize the Providers and Osceola Medical Center to file claims for payment of any portion of the patient's bills, and assign all rights and benefits payable for healthcare services to the provider or organization providing the services. I agree, subject to state and federal law to pay all costs, attorney fees, expenses, delinquent charges, and interest in the event the Providers or Osceola Medical Center have to take actions to collect the same because of my failure to pay all incurred charges in full. It is my responsibility to know what providers and telehealth/telemedicine services are covered under my insurance plan. I understand that I may be billed and agree to pay all bills submitted by the Providers, Osceola Medical Center and/or other providers involved with the provision of telehealth/telemedicine services.

Consent to be Contacted (Telephone Consumer Protection Act): By providing a telephone number (landline or cellular) or other wireless device, I agree that in order for the Providers, Osceola Medical Center and/or other providers involved with the provision of telehealth/telemedicine services to service my account(s) (including contacting me about appointment reminders, surveys, obtaining potential financial assistance for my account(s)), or to collect any amounts that I may owe, the Providers, Osceola Medical Center and/or other providers involved with the provision of telehealth/telemedicine services may contact me at the telephone number(s) provided which could result in charges to me. I expressly consent that methods of contact may include SMS text messages, phone calls, including automated technology such as an auto-dialing device, pre-recorded messages, and artificial voice messages as applicable. This consent applies to all services and billing associated with my account(s) and is not a condition of purchasing services.

By signing this document, you agree to the above consent for treatment and services through Telehealth/Telemedicine

Patient/Guardian
Signature:_____Date:_____Time:_____

Witness #1 Signature:
Signature:_____Date:_____Time:_____

Witness #2 Signature:
Signature:_____Date:_____Time:_____

(Second witness signature only needed if patient/guardian is unable to sign.)