ORTHODONTIC ASSOCIATES OF MERCER ISLAND
mercerislandsmiles.com

# CONSENT FOR TELEHEALTH SERVICES AND TREATMENT

**To our patients and families:**

Thank you for choosing us for your telehealth care. Patients and families are essential participants in health care and we want you to understand your rights and responsibilities while receiving care from us. If you have any questions about this form, please ask your provider. If you are a parent/legally authorized representative of a child, please read this agreement with the understanding that "I" and "me" means the child.

1. Consent for Treatment: I consent to telehealth care performed by my physician and all other associated health care providers at Orthodontic Associates of Mercer Island. 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 dentistry 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 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.

2. Consent for Telehealth Services: Telehealth involves transmission of video, photographs, and/or details of my medical record such as diagnostic images and laboratory test results (collectively, "Data"). All data is sent by electronic means, which may not be HIPAA complaint. Those requirements have been waived temporarily by some payors due to the Covid-19 outbreak. I understand that:

   - I will be informed of any other people who are present at either end of the telehealth encounter and have the right to exclude anyone from either location.
   - Not all visits are compatible with this technology. You may be directed to an in-person visit if indicated.
   - The technology is not perfect and periodic freezing of the audio and video can occur.
   - We will do our best to keep this visit private. This visit will not be recorded but will be documented in the medical record just like an in-person visit.
   - All confidentiality protections required by law or regulation will apply to my care.
   - I have the right to refuse or stop participation in telehealth services at any time and request alternate services such as an in-person appointment. However, I understand that equivalent in-person services might not be available at the same location or time as telehealth services.
   - If I do not want to receive health care services by telehealth, 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 encounter when I am at a non-health-care site, I should call 911 and stay on the video connection (if applicable) until help arrives.

3. Records and Release of Information: Transmitted Data may become part of my medical record. Data will not be transmitted to people outside my health care team except as described below, and/or if I provide additional written consent.

   - I will have access to all of the information in my medical record resulting from the telehealth services that I would have for a similar in-person visit, as provided by federal and state law.
   - The Providers 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.

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4. Payment Agreement/ Assignment of Benefits: I agree to be responsible for any co-payments, deductibles, or other charges from the providers that are not covered or paid by insurance or other third party payors – except as prohibited by any state or federal law, or any agreement between my insurance company and the providers of Orthodontic Associates of Mercer Island. I authorize Orthodontic Associates of Mercer Island to file any claims for payment of any portion of the patient bills and assign all rights and benefits payable for health care services to the provider or organization furnishing the services. I agree, subject to state and federal law, to pay all costs, attorney fees, expenses, delinquent charges, and interest in the event that Orthodontic Associates of Mercer Island may have to take action 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 services are covered under my insurance plan. I understand that I may be billed and agree to pay all bills submitted by Orthodontic Associates of Mercer Island who are involved with the provision of telehealth services.

**By signing this form, I acknowledge that I have read this information and agree to treatment by telehealth.**

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**Printed Patient Name**

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**Patient or Parent/ Legally Authorized Rep. Signature** **Email**

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**Printed Name & Relationship to Patient** **Date**