FLATIRON
ALLERGY & ASTHMA
CENTER

Welcome to Flatiron Allergy and Asthma Center

We are an allergy, asthma & immunology clinic. We are dedicated to providing the highest quality allergy & immunology care to our patients.

During your consultation, our physicians will obtain a detailed medical history, complete any allergy related testing (if indicated), and formulate an individualized treatment plan that best empowers you to feel confident about managing your allergic or immunologic disease.

In preparation for your consultation, we kindly request that you complete and bring with you the following information:

Demographics:

- Identification (Driver's License)
- Insurance Card
- Patient Registration Form
- Referral Letter (if required by insurance company)
- Co-pay/Payment (if required)
- Financial Policy Form
- General Policy
- HIPAA/Privacy Acknowledgement Form
- Telemedicine Consent

Clinical:

- Completed New Patient Form
- Allergy Skin Test Consent Form
- Review the Preparation for Allergy Skin Test Form
- Office Records from the Referring Physician (if applicable)
- List of Current Medications and Medication Allergies
- Recent Chest X Rays and CT Sinus Reports/Films (if applicable)

We are pleased that you have chosen us for your care and look forward to meeting you.

Sincerely,

The Staff of Flatiron Allergy and Asthma Center

PATIENT REGISTRATION FORM

FLATIRON ALLERGY & ASTHMA CENTER

For Office Use Only

Patient # _____ Location _____

Date of First Appointment _____ Patient ID Verified ☐

Patient Information

Patient's First Name _____ M.I. _____ Last Name _____

Address _____

Street City State Zip

Home Phone _____ Cell Phone _____ Social Security # _____

Date of Birth _____/_____/_____ Email _____

MM DD YYYY

Gender: M / F **Marital Status:** Married Single Divorced Other

Ethnicity: Non-Hispanice/Latino Hispanic/Latino **Race:** Caucasian African American Asian Other _____

Employer _____ Work Phone _____

Emergency Contact _____ Relationship _____ Contact Phone _____

Primary Care Physician _____ Referring Physician _____

Insurance Information

Primary Insurance _____ Group Number _____

Member ID _____ Insured Date of Birth _____

Insured Name _____ Relationship to Patient _____

Insured Employer _____

Secondary Insurance _____ Group Number _____

Member ID _____ Insured Date of Birth _____

Insured Name _____

Insured Employer _____

Responsible Party

First Name _____ M.I. _____ Last Name _____

Address _____

Street City State Zip

Home Phone _____ Cell Phone _____ Social Security # _____

Date of Birth _____/_____/_____ Email _____

MM DD YYYY

Relationship to Patient _____

Employer _____ Work Phone _____

I authorize the release of medical information necessary to process claims or obtain treatment. I request payment of benefits to Flatiron Allergy and Asthma Center. I understand I am financially responsible for charges not paid by my insurance.

I understand and agree that if my treatment at Flatiron Allergy and Asthma Center requires primary care physician referral, it is my responsibility to see that the referral is current and valid prior to receiving care at Flatiron Allergy and Asthma Center. If no referral is present in advance, I agree to pay for charges at the time of service.

Patient/Responsible Party Signature _____ **Date** _____

Relationship to Patient _____

FLATIRON ALLERGY & ASTHMA CENTER

For Office Use Only: Ht. _____ Wt: _____ Temp: _____
B/P:_____ Pulse: _____ Pulse Ox: _____

Today's Date _____ Pharmacy Name and Location _____
Patient's Name _____ Referring MD: _____
Date of Birth _____ Primary Care Provider: _____
It is ok to send you appointment reminders through email: Yes / No
How did you hear about our practice?

- ☐ Primary Care _____
- ☐ Specialist _____
- ☐ Insurance Company
- ☐ Current Patient
- ☐ Family Member/Friend
- ☐ Facebook
- ☐ Google
- ☐ Internet
- ☐ Other _____

Reason for Visit:_____

Medical History (Please Circle)

Allergies	High Blood Pressure
Anemia	High Cholesterol
Anxiety/Depression	HIV/Hepatitis
Asthma	Immunodeficiency
Autoimmune Disease	Kidney Disease
Bleeding Disorder/Clots	Liver Disease
Cancer	Lung Disease
Cataracts/Glaucoma	Seizure Disorder
COPD/Emphysema	Sleep Apnea
Diabetes	Stroke
Eczema	Thyroid Disease
GI Diseases including EOE	Tuberculosis
Heart Attack	Other _____
Heart Disease	Other _____
Heart Rhythm Abnormality	Other _____

Surgical History (Please Circle)
No Previous Surgery
Tonsillectomy
Adenoidectomy
Sinus Surgery
Nasal Polyp Surgery
Septoplasty
Cardiac Surgery
Myringotomy Tubes (ear tubes)
Thyroid Surgery
Other _____

Hospitalizations/ER Visits:
(Year of Visit/Reason)
_____
_____
_____
_____
_____

Immunization History:
Date/Year of Last Flu Vaccine:_____
Date/Year of Last Pneumonia Vaccine: _____
Date/Year of COVID 19 Vaccine:_____

Social History:
Marital Status: _____
Occupation: _____
Hobbies/Interest: _____
Smoking: Never/ Current/ Former
If so, How Much _____
How Long _____
Quit Date _____
Alcohol: Never __ Rare __ Social __ Daily __
Marijuana and/or Recreational Drug Use? Yes/No

Food Allergy & Reactions:
_____
_____
_____

Latex Allergy: Yes/No
Insect Adverse Reaction: Yes/No
If so, to:
Bee/ Wasp/ Yellow Jacket/ Hornet/ Fire-ant
Mosquito/ Other
Eczema: Yes/No
If so, triggers:
Environmental/ Chemical/ Metal/ Food
Current Pregnancy: Yes/ No

If Patient is a child:
Child Lives with:_____
Mother/Father's Full Name: _____
Mother/Father's Full Name: _____
Attends Daycare: Yes/No
Exposed to second-hand smoke: Yes/No
Birth History: Vaginal/C-Section
Birth Weight: _____ pounds

FLATIRON
ALLERGY & ASTHMA
CENTER

Date of Last Chest X-ray: _____
Date of Last Lung Test: _____

Family Medical History

	Mother	Father	Children	Siblings
Allergy				
Angioedema (swelling)				
Asthma				
Drug Allergy				
Eczema				
Food Allergy				
Hives				

Past Allergy Testing:
Never Tested Before
Prior Skin Test: **Yes/No** - Year: _____
Prior Blood Test: **Yes/No** - Year: _____
Allergic to:
pollen/dander/food/chemicals/venom/other
Prior Allergy Shots: **Yes/No** - Year: _____
Currently on Allergy Shots: **Yes/No**

Date of Last Sinus CT Scan:_____

Environmental History
Where do you live? City/ Country/ Farm/ Rural
Is your home: Single Family/ Apartment/ Condo/ Townhome/ Mobile Home
How long have you been in Colorado? __ months/years
Heating: **(Circle One)** Gas/ Electric/ Baseboard/ Forced Air/Fireplace (wood burning/gas/electric)
Cooling: Air Conditioner/ Swamp Cooler/ Window Fan
Flooring: Hardwood/Carpeting/Other: _____
Mattress: Spring/Foam/Waterbed/Other. Years old: _____
Pillow: Feather/Foam/Synthetic. Years old: _____
Visible Mold or Water Damage? Yes/No
If Yes: Mild/Moderate/Severe
Humidifier? Yes/No **Setting**: _____
Air Purifier: Yes/No
Do you have pets or animal exposure?
Type of animal(s):_____

Drug Allergy/Reaction:
_____
_____
_____

Current Medications OR BRING A CURRENT LIST

Medication	Name	Dose

Review of Systems: (Please Circle)
General/Constitutional: fatigue, fevers, headache, recent illness, weight gain, or weight loss
Eyes: contact lenses/glasses, disease or injury, itchy, pain, redness, watering, vision change
Ears/Nose/Throat/Neck: frequent sinus infections, hearing loss, itchy nose, nasal stuffiness, bleeding, pain, post-nasal drip, ringing of ears, runny nose, sneezing, snoring, masses in thyroid
Cardiovascular: chest pain, heart murmurs, or hypertension
Respiratory: cough, respiratory infections, shortness of breath, or wheezing
Gastrointestinal: abdominal pain, constipation, diarrhea, difficulty with swallowing, indigestion/heartburn, nausea, or vomiting
Genitourinary: frequency, infections, or urgency
Musculoskeletal: limitation of motion, pain, or swelling
Skin: dryness, eczema, hives, itching, or rash
Neurologic/Psychiatric: anxiety, depression, or seizures
Endocrine: diabetes, glandular problem/thyroid disorder, or intolerance to heat or cold
Hematologic: anemia, bleeding tendency, or previous transfusions and reactions
Allergic/Immunologic: frequent infections, reactions to: foods/insects/medications/vaccine

FLATIRON
ALLERGY & ASTHMA
CENTER

GENERAL POLICIES

Thank you for choosing Flatiron Allergy & Asthma Center (FAAC) as your health care provider. We are committed to building a successful physician-patient relationship with you and your family. Your understanding of our policies is important to our professional relationship.

1. I understand that medications are unable to be refilled if I have not followed up within the requested interval.

2. I understand that I may be charged for telephone calls to the provider.

3. I may be asked to reschedule if I am more than 10 minutes late for my appointment.

4. I understand I will be charged a fee of $5 for the completion of each page on a school form. School forms will be not charged if such forms are brought in during a scheduled office visit.

5. I understand I will be charged fees in accordance to Colorado law for copies of my medical records.

6. I understand I will be charged a fee of $25 for each letter prepared by FAAC.

7. I understand I will be charged a $50 fee for no shows or cancellations within 24 hours of the scheduled appointment.

_____ _____
Signature of Patient (or Parent/Guardian for Minor Patient) Date

_____
Printed Name of Patient

FLATIRON
ALLERGY & ASTHMA
CENTER

FINANCIAL POLICIES

Please understand that Flatiron Allergy and Asthma Center's (FAAC) financial policies are established to ensure the financial resources needed to maintain this medical office for all our patients. We must emphasize that as a health care provider our relationship is with you and not your insurance company.

It is your responsibility to inform our office of any patient information changes including name, address, and insurance information.

Please read and sign the following financial policies indicating your understanding of these policies and accepting financial responsibility for all services provided. Please ask us if you have any questions about our fees, policies, or your responsibilities.

Insurance

- The patient is required to present an insurance card at each visit. It is the patient's responsibility to make sure that all insurance information given to our office is correct and current, including both primary and secondary insurance. Failure to provide us with correct insurance information could result in your insurance company rejecting your claims for failure to obtain authorization, timely filing or other reasons and may result in your responsibility for the entire bill.

- FAAC will bill your insurance company. It is your responsibility to verify your coverage and adhere to the restrictions of your plan. Your insurance is a contract between you, your employer if applicable, and your insurance company. Please contact your insurance company and/or your employer's human resource department with regards to your benefit questions. Although we may estimate what your insurance company may pay, it is your insurance company that makes the final determination of your eligibility and benefits.

- You may be responsible for charges incurred in this office that are not paid by your insurance company, including those applied to your deductible or coinsurance, in accordance with FAAC's fee schedule and terms, regardless of insurance coverage. We don't always know if you have a deductible, if your deductible has been met, or if you have coinsurance.

- We expect payment in full of deductible and coinsurance balances within 30 days of statement receipt unless prior payment arrangements have been made. If services are performed or appointments made that are not covered by your insurance plan, you may be responsible for payment. We may ask that non-emergency appointments be rescheduled if copayment is not paid.

- I authorize my insurance company to make payments directly to FAAC. I authorize the release of any medical information necessary to process claims and/or pursue payments of this account.

Self-Pay or Insurance FAAC does not participate with

- You will need to sign a self-pay waiver if you have no insurance. This waiver clarifies your financial responsibly and helps prevent misunderstandings.

Referrals

- It is your responsibility to list a physician if your insurance company requires a PCP and call for a referral if one is required. Certain health insurances require that you obtain a referral or prior authorization from your Primary Care Provider (PCP) before visiting a specialist.

- Failure to obtain the referral and/or preauthorization may result in a lower or no payment from the insurance company, and the balance may be your responsibility.

FLATIRON
ALLERGY & ASTHMA
CENTER

Imaging and Laboratory Fees

- Imaging and Laboratory services are performed and billed by an outside provider. You will be billed from their office and all payments, questions or other concerns should be directed to their office. Flatiron Allergy and Asthma cannot accept payments or adjust these outside provider charges.

Minor Patients

- The parent/guardian accepts financial responsibility for all services provided by FAAC to a minor patient, regardless of who is the subscriber on the insurance policy.
- Payment of services is due by the adult accompanying any minor child unless other arrangements have been made in advance.
- FAAC will not bill two people for care of a minor patient. It is the responsibility of the accompanying adult to pay the amount due in full, and collect what is owed by others.
- FAAC is not party to any legal agreements between divorced or separated parents and therefore is not bound by the terms of any such agreements.

Returned Checks

- There will be a $50.00 charge in addition to any charged bank fees for returned checks. This fee will be applied to my debit/credit card on file. All future payments must be paid with a debit/credit card.

Payment

- I understand that FAAC requires that a credit card (we accept Visa, Mastercard, and Discover), debit card or health savings account card be kept on file and will be billed for any balance owed by the patient.
- If the credit card or health savings account card I provide on file is declined, I understand that I will be charged an extra $50 re-processing fee.
- Accounts past due are subject to collection proceedings and ultimately dismissal for full collection accounts.
- I agree that if my account becomes delinquent, I will be responsible for Attorney Fees, Legal Costs or any other costs of collection that may be incurred in order for FAAC to obtain payment.

I take responsibility for researching the costs of my visit and any procedures related to the visit with my insurance company and understand that costs not covered by certain insurance will be charged to me. I understand that I can discuss any visit related charges ahead of the visit with Flatiron Allergy and Asthma Center's billing department at 970-430-4896.

I have read and accept the terms of this financial policy.

_____
Printed Name of Financial Responsible Party

_____ _____
Signature of Financially Responsible Party Date

FLATIRON
ALLERGY & ASTHMA
CENTER

PATIENT CONSENT FORM FOR ALLERGY SKIN TESTING

Purpose:
Allergy skin testing is performed to assess for allergy antibodies to:

- environmental allergens (pollen, animal proteins, dust mite, mold, cockroach)
- food allergens
- insect venoms (honeybee, yellow jacket, yellow hornet, white faced hornet, paper wasp, fire ant)
- medications such as penicillin

Procedure:
Skin tests are methods of testing for allergic antibodies. A test consists of introducing small amounts of the suspected substance, or allergen, into the skin and noting the development of a positive reaction (which consists of a hive (swelling and redness). The results are read at 15 to 20 minutes after the application of the allergen. The skin test methods are:

Prick:
In prick allergy skin testing, a sharp plastic lancet is passed through the allergenic extract or control solution, the skin on the back or forearm is lifted and a small break in the epidermis is created through which the extract or solution penetrates. If an allergenic sensitivity is present, a hive/welt like reaction develops in the area of prick.

Intradermal:
Intradermal allergy skin testing is most commonly completed adjunctively to negative prick testing in evaluation of environmental, venom, and drug allergy. In intradermal skin testing, a small needle is used to inject the allergenic extract or control solution into a deeper layer of skin, called the dermis, on the arm. If an allergenic sensitivity is present, a hive/welt like reaction develops in the area of intradermal application.

Interpretation:
Interpreting the clinical significance of skin tests requires skillful correlation of the test results with the patient's clinical history. Positive tests indicate the presence of allergic antibodies and are not necessarily correlated with clinical symptoms.

If you have a specific allergic sensitivity to one of the allergens, a red, raised, itchy bump (caused by histamine release into the skin) will appear on your skin within 15 to 20 minutes. These positive reactions will gradually disappear over a period of 30 to 60 minutes, and, typically, no treatment is necessary for this itchiness. Occasionally local swelling at a test site will begin 4 to 8 hours after the skin tests are applied, particularly at sites of intradermal testing. These reactions are not serious and will disappear over the next week or so.

Risks:
Skin testing will be administered at this medical facility with a medical physician or other health care professional present since occasional reactions may require immediate therapy. These reactions may consist of any or all of the following symptoms: itchy eyes, nose, or throat; nasal congestion; runny nose; tightness in the throat or chest; increased wheezing; lightheadedness; faintness; nausea and vomiting; hives; generalized itching; and shock, the latter under extreme circumstances. Please let the physician and nurse know if you are pregnant or taking beta-blockers. Allergy skin testing may be postponed until after the pregnancy in the unlikely event of a reaction to the allergy testing and beta-blockers are medications they may make the treatment of the reaction to skin testing more difficult.

Please note that these reactions rarely occur but in the event a reaction would occur, the staff is fully trained and emergency equipment is available.

FLATIRON
ALLERGY & ASTHMA
CENTER

Alternatives:
Allergy skin testing is considered superior and less expensive than specific IgE blood tests in the diagnosis of allergy.

After skin testing, you will consult with your physician or other health care professional who will make further recommendations regarding your treatment

Please do not cancel your appointment since the time set aside for your skin test is exclusively yours for which special allergens may be prepared. If for any reason you need to change your skin test appointment, please give us at least 48 hours-notice. Due to the length of time scheduled for skin testing, a last-minute change results in a loss of valuable time that another patient might have utilized.

I have read the patient information sheet on allergy skin testing and understand it. The opportunity has been provided for me to ask questions regarding the potential side effects of allergy skin testing and these questions have been answered to my satisfaction. I understand that every precaution consistent with the best medical practice will be carried out to protect me against such reactions.

Patient_____ Date signed_____

Parent or legal guardian*_____ Date signed_____
*as parent or legal guardian, I understand that I must accompany my child throughout the entire procedure and visit.

Witness _____ Date signed_____

FLATIRON
ALLERGY & ASTHMA
CENTER

PREPARATION FOR ALLERGY SKIN TESTING

As part of your allergy consultation, allergy skin testing maybe indicated. The interpretation of these tests can be adversely affected by use of antihistamine medications and those medications with antihistaminic activity.

To best ensure a high-quality allergy skin test, it is necessary to avoid the following medications as listed below:

Please discontinue the following medications, as well as any over-the counter allergy & sinus medications for at least 5 days prior to your visit:

- Alavert (Loratidine)
- Alaway (Ketotifen)
- Allegra (Fexofenadine)
- Astepro (Azelastine)
- Azelastine
- Atarax (Hydroxyzine)
- Chlortrimeton (Chlorpheniramine)
- Clarinex (Desloratidine)
- Claritin (Loratidine)
- Dimetapp (Brompheniramine)
- Dymista (Azelastine + Fluticasone)
- Nyquil (Doxylamine)
- Optivar (Azelastine)
- Patanase (Olopatadine)
- Tavist (Clemastine)
- Vistaril (Hydroxyzine)
- Xyzal (Levocetirizine)
- Zaditor (Ketotifen)
- Zyrtec (Cetirizine)
- Zyrtec Itchy Eyes (Ketotifen)

Please discontinue the following medications for at least 2 days prior to your visit:

- Axid (Nizatidine)
- Benadryl (Diphenhydramine)
- Pepcid (Famotidine)
- Tagamet (Cimetidine)
- Zantac (Ranitidine)

The application of topical steroids to the forearms and back should be avoided for at least 2-3 weeks prior to your visit.

Medications such as benzodiazepines, tricyclic antidepressants, as well as other antidepressants may suppress responses to skin testing. If you are on these medications, please contact the prescribing physician and inquire if these medications can be safely stopped.

You can continue to take inhaled, nasal, and oral steroids without interfering with allergy skin testing.

Allergy skin tests are generally safe, but rarely life-threatening allergic reactions may occur. Symptoms of such reactions can include hives, swelling, breathing troubles, and low blood pressure.

Due to this risk, it is important that you let us know if you have a history of anaphylaxis, unstable asthma, are pregnant, and/or are on beta blockers, ACE inhibitors, or MAO inhibitors. Having these conditions, being pregnant, or being on these medications may make a rare allergic reaction to skin testing more severe and/or more difficult to treat.

FLATIRON
ALLERGY & ASTHMA
CENTER

PRIVACY PRACTICES

Flatiron Allergy & Asthma Center
Principal Location: 90 Health Park Dr. Suite 170. Louisville, CO 80027
Holly Lohr - Office Phone: 303.862.3303

Acknowledgement of Receipt of Notice of Privacy Practices

I have reviewed this medical practice's current Notice of Privacy Practices as posted in the reception area.

If not signed by the patient, please indicate relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient

I authorize the following persons to consent for needed treatment in my absence for

_____ (Minors only)

Name:	**DOB:**
_____	_____
_____	_____
_____	_____
_____	_____

Communication of Medical Issues: such as test results, you can choose more than one

□ Phone ( ) _____ □ OK to leave a message including results or other health related information

□ Not OK to leave a message

□ U.S. Mail

Verbal Communication of Protected Health Information

I authorize the following individuals to inquire and receive verbal information regarding my care and sign a records release.

(Actual release of medical records requires a separate form)

1. _____ Relationship _____ Date of Birth _____

2. _____ Relationship _____ Date of Birth _____

Signature of Patient or Guardian: _____

Print Name: _____

Date: _____ Telephone: _____

FLATIRON
ALLERGY & ASTHMA
CENTER

CREDIT CARD ON FILE AUTHORIZATION FORM

Keeping a credit card on file has its benefits:
It's convenient (saving you time and postage).
Your payment is always on time (even if you're out of town).
You can get your credit company's reward points for paying your bill.
You SAVE money by avoiding late fees.

Here's How it Works:

You authorize Flatiron Allergy & Asthma Center to keep your credit card number on file and use it to bill any outstanding balances after third parties pay their portion.

Once all third parties, including your medical insurance, have paid their portion you will receive a statement and have 30 days to review it before your card is charged.

You will receive a reminder call a week before we charge your card. A message will be left if we reach your voicemail.

I _____ authorize Flatiron Allergy & Asthma Center to charge my credit card indicated below for my outstanding balance on an as needed basis.

_____ _____
Billing Address Phone Number

_____ _____
City, State & Zip Code Email Address

_____
Patient Names (list all)

I authorize Flatiron Allergy & Asthma Center (FAAC) to charge the credit card indicated in this authorization form according to the terms outlined above. I understand I may revoke this authorization by providing a written request at least 15 days prior to my card being processed. I understand that FAAC policy is to have a credit card on file for payment and if authorization is revoked without providing another credit card, FAAC may not be able to provide future services. I understand that this authorization will remain in effect until the designated card's expiration date or until I cancel it in writing, whichever comes first, and I agree to notify FAAC in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. I understand that should my credit card be declined, I may be subject to a $25.00 re-processing fee. I certify that I am an authorized user of this credit card and that I will not dispute the payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form. I agree to promptly submit written notification to Flatiron Allergy & Asthma Center if my credit card is cancelled, lost or stolen.

Signature: _____

Date: _____

FLATIRON
ALLERGY & ASTHMA
CENTER

TELEMEDICINE CONSENT

Name: _____ Date of Birth _____ Today's Date/Time_____

Introduction:

Telemedicine involves the use of electronic communications to enable health care providers at different locations to communicate with patients for the purpose of improving patient care. Providers may include primary care practitioners and specialists.

The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

- Improved access to medical care by enabling patients to remotely contact their medical provider.
- More efficient medical evaluation and management

Possible Risks:

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images, lack of in person physical exam and other procedures such as spirometry) to allow for appropriate medical decision making by the physician and consultant(s)
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors

Initial: _____

FLATIRON
ALLERGY & ASTHMA
CENTER

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.
2. 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 affecting my right to future care or treatment.
3. I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction, and may receive copies of this information for a reasonable fee.
4. I understand that a variety of alternative methods of medical care may be available to me such as in person patient visits, and that I may choose one or more of these at any time.
5. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

Patient Consent To The Use of Telemedicine

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

_____ _____

Patient or Guardian Date