Allergy and Asthma Center Anita N. Wasan MD PLC
6824 Elm St, Ste 120 Mclean, VA 22101
Tel: 703-992-7065, Fax: 703-992-7063 www.novaallergy.com

PHONE CONSULTATION PATIENT CONSENT FORM:

ESTABLISHED PATIENTS ONLY

We are unsure how individual insurance companies, including Medicare and commercial, will be covering the phone consultations. While we want to continue providing quality health care to all our patients, we also need to pay our bills and employees. Therefore, we are requesting Allergy and Asthma Center patients acknowledge the following:

1. I understand that all federal and Virginia state laws protecting the privacy and confidentiality of medical information also apply to phone consultations.
2. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties.
3. I understand that my healthcare provider or I can discontinue the phone consult/visit and future phone visits at any time. I understand that withdrawal of my phone consent will not affect my future care nor treatment with this company.
4. I understand that certain procedures such as a complete physical exam, allergy testing, or pulmonary function testing cannot be performed via telephone.
5. I understand my health care provider may feel the phone discussion may not be adequate and may request an actual visit to the office for more detailed consultation and examination. If that is so, I will only be charged for the in-office consultation.
6. I understand that my insurance may not pay for this phone consultation service, even if my provider feels this is a healthcare treatment option I need.
7. I understand that I will be required to pay the applicable co-pay before the visit occurs. Our staff will do their best to verify that my insurance covers telemedicine visits. However, if this visit is deemed as not part of my insurance benefits, I understand that I am responsible for the office cash-price fee of **$75** as an already established patient of the practice. Phone consultations are **NOT** available for new patients.

My Responsibilities:

1. I will not record any telephone session without written consent from the Allergy and Asthma Center. My healthcare provider will not record any telephone session without my written consent
2. I will inform my healthcare provider as soon as my session begins if there are any other surrounding people that are listening or watching the session. If there are surrounding people that will stay for the session, I am giving my consent for them to listen in on my medical care.

3. I will notify my healthcare provider if there is any point in the consultation that my equipment fails and I am unable to have clear audio.

Regarding payment for services rendered, I am requesting the option below:

- (Option 1) I want my insurance to be billed for this telephone visit and will pay the applicable copay before the consultation. However, if my insurance company does not pay for the visit, then I am responsible for the office cash-price fee of **$75.00**. If my insurance does pay, the Allergy and Asthma Center will refund any payments I made, less copays or deductibles.
- (Option 2) I will pay for the office cash-price fee of **$75.00** (and insurance will not be billed. I will not attempt nor request the Allergy and Asthma Center to file any claims at a later time to any insurance carrier for coverage of services rendered to me for this telemedicine visit.
- (Option 3) I decline the option for the telephone consultation.

In signing my consent below, I certify:

- That I have read or had this form read and/or had this form explained to me
- That I fully understand its contents including the risks and benefits of the procedure(s)
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

_____ _____

Patient's/parent/guardian signature Date