Allergy and Asthma Center
6824 Elm St. STE 120
Mclean, VA 22101
Tel: 703-992-7065, Fax: 703-992-7063
www.novaallergy.com

Date of Visit:			
Patient Name:			DOB:
Address:	City:	State:	Zip:
Cell Phone Number:			
Alternate Number:			
Insurance Name and ID:			
Subscriber Name, Middle Initial & DOB:			
Preferred Pharmacy Name (Include Address & Zip code)			
Please list primary care provider and any specialist physicians you see, including city, state and phone number:			
Any drug allergies? If yes, please list approximate age of reaction and symptoms, **INCLUDE SEVERITY**: Very mild / Mild / Moderate / Severe			
List all medications (PRESCRIPTION MEDS AND OVER THE COUNTER) **INCLUDE DOSING:**			

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TELEMEDICINE PATIENT CONSENT FORM

Telemedicine, according to the Centers for Medicare & Medicaid Services, is "the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance." There are multiple criteria (video face-to-face consultation, for example) for both patient and provider to fulfill in order for a consultation to be deemed an appropriate Telemedicine visit.

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 telemedicine.
2. Video conferencing with your provider will be through the HIPAA compliant telemedicine service provider DOXY.ME.
3. My healthcare provider has explained to me how the video conferencing technology will be used and that the visit may not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.
4. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties.
5. I understand that my healthcare provider or I can discontinue the telemedicine consult/visit and future telemedicine visits at any time. I understand that withdrawal of my telemedicine consent will not affect my future care nor treatment with this company.
6. I understand that certain procedures such as a complete physical exam, allergy testing, or pulmonary function testing cannot be performed via telemedicine.
7. I understand my health care provider may feel the telemedicine 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.
8. I understand that my insurance may not pay for this telemedicine service, even if my provider feels this is a healthcare treatment option I need.

My Responsibilities:

1. I understand that I must be physically within the state of Virginia or District of Columbia (including offshore State waters) to be eligible for telemedicine and that my healthcare provider can send prescriptions for medications only to Virginia pharmacies or addresses. My provider will not be sending narcotic medications through a telemedicine-based consultation.
2. I will not record any telemedicine session without written consent from the Allergy and Asthma Center. My healthcare provider will not record any telemedicine session without my written consent
3. 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
4. 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

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 Signature: _____ Date: _____

Patient Name: _____

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Release of Medical Information

Patient Name _____ DOB _____

Address _____

City, State, Zip _____

Telephone Number (Mobile) _____

(OFFICE STAFF TO FILL OUT REQUEST)

I authorize the release of my medical records to:

_____

My medical records are to be released from:

_____

Date of treatment: _____ Send via: _____

Record Content: _____

I, the undersigned, have read the above and authorize the staff of the disclosing facility named to disclose such information as herein contained. I understand that this consent may be withdrawn by myself at any time except to the extent that the action has been taken in reliance upon it. I acknowledge and hereby consent that the released information may contain HIV testing, HIV results, and/or AIDS information. The facility (Anita N. Wasan MD PLC) is released and discharged of any liability, and the undersigned will hold the facility harmless for complying with this Authorization for Release of Medical Information.

Date: _____ Relationship of Undersigned to patient: _____

Signature: _____