

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, a patient of the Center for Pain Management, LLC do request to have provider/patient interactions in the form of e-visits, telehealth visits and/or virtual check ins as determined by the provider. I understand that this will include the sharing of personal health information via the phone, internet or other electronic means that may not be completely secure, but feel that for these encounters, electronic interactions are an appropriate mechanism for my health care needs.

I further understand that the possible risks associated with using telehealth, may result in poor transmission of information, including poor resolution of images; could result in delay of medical evaluation and treatment if there are any failures in the technology and the provider may not have all of the diagnostic tools, data and information available at the time of the telehealth visit.

I further understand that I am financially responsible for any of the visits or check ins that my insurance company (if any) determines to be not medically necessary or non-covered. I understand that although the insurance company may have policies that may prohibit payment, I am ultimately responsible for payment for these encounters.

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Patient Signature/Responsible Party Signature Date

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Printed Patient Name/Responsible Party Name