A division of:
325 Tamarack Lane / Shiloh, IL 62269 // 2023 Vadalabene Drive / Suite 151 / Maryville, IL 62062
(618) 250-4688 / Fax (618) 624-2226 / www.quellheadache.com / info@quellheadache.com

Quell Telehealth/Telemedicine Consent Form

Consent Type: Verbal / Written

Telehealth or telemedicine means that you will be evaluated and treated by our healthcare provider or providers from a distant location via electronic (telephony/video) communication. Since this is different than a typical in-person visit, it is important you to understand and agree to the following terms.

1. I understand that my healthcare provider at Quell Headache & Wellness (Quell) Allergy, Asthma & Immunology Center, SC (AAIC), wishes me/my child to engage in a telemedicine visit.
2. I understand that Quell/AAIC has advanced practice Providers (e.g. nurse practitioners and physician assistants) and Staff (e.g. medical assistants, registration/billing/other personnel) who may participate in the care of the patient under the supervision of the attending physician.
3. It has been explained to me how the video conferencing technology will be used to conduct a visit and I understand this visit will not be the same as an in-person visit due to the fact that I/my child will not be in the same room as the healthcare provider who is at a distant site. Additional medical or registration personnel may also be present in the room with the Provider during the telemedicine visit.
4. I hereby authorize and voluntarily consent to Quell/AAIC and its employees to provide me/my child with basic treatments and medical and diagnostic procedures.
5. I understand there are potential risks to this technology, including, but not limited to, interruptions, unauthorized access, technical difficulties and call termination.
6. I understand there are alternatives and limitations to this type of care. I understand that my healthcare provider or I can discontinue my/my child's telemedicine visit if it is felt that the videoconferencing connections are not adequate for the situation.
7. I understand that I may be released before all my medical problems are known and/or treated and it is my responsibility to make sure such symptoms/conditions are known to the medical personnel and I agree to seek urgent or emergent in-person care if my/my child's condition changes or worsens.
8. I understand that my/my child's healthcare information may be shared with other individuals for treatment, healthcare operations and billing purposes. Furthermore, I grant permission to release any and all information in connection with rendered services to third party payor(s), their representatives and collaborating physician(s) involved in the patient's care.

9. I understand that third party payors may or may not include coverage for telehealth/telemedicine service as a covered benefit. Coverage may change from time to time, but as of 3/19/2020, the Governor of Illinois's executive order provides coverage for "all costs of Telehealth Services rendered by in-network providers to deliver any clinically appropriate, medically necessary covered services and treatments to insureds, enrollees, and members under each policy, contract, or certificate of health insurance coverage." I understand this policy could change at any time and that I am responsible for any unpaid bills not covered by third party payors, including Medicare. Furthermore, I understand that a copayment and/or insurance deductible payment (depending on your insurance's guidelines) may be due and is collectable at the time services are rendered and cannot be refunded once the telemedicine visit has begun.
10. The cash price for our specialist, allergy and clinical immunology telehealth/telemedicine service is $300/hr, billed in 20-minute increments. Most visits are completed in 20 minutes or less. Reduced rates are available for low-income and uninsured patients.

The below signing party affirms that they are either the patient, parent or legal guardian of the patient and has the full legal authority to seek medical care on behalf of the patient.

_____ _____

Patient Name or **Legal Representative** (**Print**) **Patient/Parent/Guardian Signature** and **Date**

_____ _____

Staff performing Verbal Consent **Signature** and **Date** **Witness** to Verbal Consent **Signature** and **Date**

Printed Name: **Printed Name:**