ALLERGY & ENT ASSOCIATES

Telemedicine Informed Consent/Credit Card Pre-Authorization Form

PATIENT NAME:_____	**Location:**_____
Patient Date of Birth:_____	**MRN:**_____
	Office Use Only

I understand that telemedicine is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider. Every effort to ensure your privacy is made when using this technology. I hereby consent to Allergy & ENT Associates providing health care services to me via telephonic or virtual device.

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine. As always, your insurance carrier will have access to your medical records for claim processing, quality review and/or audit.

I understand that I will be responsible for any co-payment, deductible or coinsurance that apply to my telemedicine visit. **I authorize my credit card information to be securely stored and payment processed once my telemedicine visit has occurred.**

Name on Card:_____

Credit Card Number:_____

Expiration Date:_____

Card Type (Check one): ☐ **VISA** ☐ **MC** ☐ **DISCOVER**

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 treatment.

I may revoke my consent orally or in writing at any time by contacting Allergy & ENT Associates. As long as this consent is in force Allergy & ENT Associates may provide health care services to me via telemedicine without the need for me to sign another consent.

Questions or concerns regarding insurance or billing should be directed to the Front Desk or Centralized Business Office at 281-874-0400.

*****Computer or Cell phone must have audio and visual capability******

_____ _____

Name (Parent or Guardian) Please Print Signature

_____ _____

Witness Date