Chronic Disease Management
Consent Agreement

Patient Name:___________________________________
MRN:_____________

Informed Consent for Treatment

Alliance Health provides integrated primary medical, disease self management, and other health care services to meet your needs regardless of your age, gender, gender identity, color, race, ethnicity, creed, national origin, religion, disability, sexual orientation or veteran status. The purpose of that care is to:

- Obtain information through a history and assessment for diagnosis and developing a plan of care
- Treat disease, injury, and disability by testing, use of procedures, therapies, and medications
- Aid patients in achieving their maximum potential within their capabilities
- Accelerate patients/clients gradual return to health and strength after illness, and reduce the length of the functional recovery, however, this outcome is not guaranteed.

Referrals will be made to other agencies and providers that are appropriate to the needs of the patient. This may include a referral to other specialist or rehab programs focusing on cardiology, pulmonology or endocrinology in the community.

As part of your integrated care, we use an electronic health record that includes your medical, and other health information. In order to give you the best care possible, all of your care team may view the complete record, including information related to your care plan developed by your doctors.

You will have the option of receiving treatment in the office or through the use of tele health visits. Telehealth involves the use of electronic communications including (1) live two-way audio and video; (2) interactive audio and messaging via telephone to enable healthcare providers at different locations to provide patient care and self-management education. Telehealth services offered by Alliance Health may also include chart review, appointment scheduling, health information sharing, and non- clinical services, such as patient education. The information you provide may be used for diagnosis, therapy, follow-up and/or patient education, and may include any combination of the following: (1) health records and test results; and (2) output data from medical devices and sound and video files.

The electronic communication systems we use will incorporate network and software security protocols to protect the confidentiality of patient identification and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits of Tele Health:

Improved access to care by enabling you to remain in your home.

More efficient care evaluation and management.

Obtaining expertise of a specialist as appropriate.

Possible Risks of Tele Health:

Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment and technologies.

In rare events, our provider may determine that the transmitted information is of inadequate quality, thus necessitating a rescheduled telehealth consult or an in-person consult.

In very rare events, security protocols could fail, causing a breach of privacy of personal medical information.

By signing below, you acknowledge that you understand and agree with the following:

1. I hereby consent to receiving Alliance Health services via telehealth technologies. I understand it is up to the provider to determine whether or not my specific clinical needs are appropriate for a telehealth encounter.

2. I understand that federal and state law requires health care providers to protect the privacy and the security of health information. I understand that Alliance Health will take steps to make sure that my health information is not seen by anyone who should not see it.
3. I understand there is a risk of technical failures during the telehealth encounter beyond the control of Alliance Health. I agree to hold harmless Alliance Health for delays in evaluation or for information lost due to such technical failures.

4. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment. I understand that I may suspend or terminate use of the telehealth services at any time for any reason or for no reason. I understand that if I am experiencing a medical emergency, that I will be directed to dial 9-1- 1 immediately and that Alliance Health providers are not able to directly connect me to local emergency services.

5. I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.

6. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes.

The signature below at the bottom of this page provides Consent for Telehealth Treatment. I fully understand that this consent is given in advance of a specific diagnosis or treatment. I am also aware that this consent will remain in effect until revoked in writing. My consent will be carried over to other Alliance Health locations should I choose another provider or service within this organization.

Financial Agreement

I understand that Alliance Health will charge fees for the service rendered for my care. These fees may be estimated at times based on anticipated services to be provided, but will always be adjusted to the actual fees associated with the exact services that were provided to me. To ensure Alliance Health bills my insurance company correctly, I am responsible for providing Alliance Health with accurate insurance information.

If I have medical insurance, Alliance Health will bill my insurance company the fees referred to above. I acknowledge and understand that I am responsible to know what medical services my insurance company will cover or not. I also understand that at this time I will not be responsible to pay for the amount that my insurance company will not cover, which includes insurance co-pays and/or deductibles. If I have no insurance, I understand that the fees charged to me are at this time not my responsibility. If Alliance Health will no longer be responsible for co-pays and/or deductibles, I will be notified before services are rendered.

If I have been injured at work or in an accident, I am responsible to provide Alliance Health with the necessary Worker's Compensation or Auto Insurance billing information so that Alliance Health can bill the appropriate responsible party.

Acknowledgment

My signature indicates that I have read and understand all of the information above and on page one of this form. I understand that:

- My initial assessment does not guarantee enrollment into Alliance Health's Chronic Disease Management Program and if I am admitted, I will be limited to as many interventions deemed necessary by the Health Educator to meet all necessary self-management goals.
- The demographic, billing, and insurance information I have provided to Alliance Health is correct. I know it is my responsibility to provide up to date information at every visit.
- I am not responsible at this time to pay any copays, coinsurances, deductibles, or other costs related to my telehealth treatment, which may be due at the time of service.
- I will be notified when services are no longer covered including copays, coinsurances, deductibles, or other costs prior to any services being performed.
- I have been given an opportunity to ask questions regarding my consent. All my questions have been answered.
- Alliance Health's Chronic Disease Services are currently limited to the treatment of diabetes, congestive heart failure and chronic obstructive pulmonary disease. If I need a higher level of care, I will be referred to another specialty provider in the community.
- Alliance Health will follow State & Federal laws in regard to protecting my medical and demographic information. My information is confidential, but my Health Educator will consult with my provider, his/her program supervisor, other members of my care team, and the consulting pharmacy team on an ongoing basis.

The signature below provides Consent for Telehealth Treatment. I fully understand that this consent is given in advance of a specific diagnosis or treatment. I am also aware that this consent will remain in effect until revoked in writing. My consent will be carried over to other Alliance Health locations should I choose another provider or service within this organization.

I am requesting treatment and give consent for treatment for (select one only):

Myself Patient Name (if patients guardian): ____________________________________

Documentation of relationship provided & scanned into chart:

Custodial Parent Legal Guardian License Court Appointed Other: _______________

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Signature of Patient or Representative Date