Dr. Fernandez Integrative Care

TELEHEALTH SERVICES POLICY WAIVER,

HIPAA TELEHEALTH CONSENT

& FINANCIAL RESPONSIBILITY ACKNOWLEDGMENT

Patient Name: _____

Date of Birth: _____

If the patient is a minor, the undersigned confirms they are the patient's parent or legal guardian and have the legal authority to consent to care and accept financial responsibility.

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1. Telehealth Services Acknowledgment

I understand and acknowledge that telehealth services may include video conferencing, telephone communication, secure messaging, and other electronic technologies used to provide healthcare services remotely. I understand that telehealth has limitations when compared to in-person services and may not be appropriate for all medical conditions.

You must have legal residence in the state of Florida and be in the state of Florida at the time of telehealth service with the provider.

To participate in our telehealth services, you must still be seen in person in our office at least once per year.

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2. HIPAA Telehealth Consent & Privacy Acknowledgment

I understand that telehealth services involve the electronic transmission of my protected health information ("PHI"). I acknowledge and agree to the following:

- Telehealth services will be provided using technology designed to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- Despite reasonable safeguards, there is a potential risk of unauthorized access, technical failure, or interception of electronic communications.
- I consent to the use, disclosure, and transmission of my PHI for the purposes of diagnosis, treatment, payment, and healthcare operations as permitted under HIPAA.
- I understand that telehealth sessions **will not be recorded** without my explicit consent, unless otherwise required by law.
- I have the right to request alternative methods of communication or in-person services, subject to availability.

By signing this waiver, I knowingly and voluntarily consent to receive healthcare services via telehealth and authorize the electronic exchange of my PHI as described above.

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3. Medicare Non-Coverage Notice (Effective After January 30, 2026)

I acknowledge and understand that **telehealth services provided by this practice are considered a NON-COVERED SERVICE by Medicare after January 30, 2026**.

Starting January 31, 2026, you **must live in a rural area and go to an office or medical facility that's also in a rural area (in the U.S.) for most telehealth services**. If you aren't in a rural area, you can still get these Medicare telehealth services on or after January 31:

- Monthly End-Stage Renal Disease (ESRD) visits for home dialysis
- Services for diagnosis, evaluation, or treatment of symptoms of an acute stroke wherever you are, including in a mobile stroke unit
- Services for the diagnosis, evaluation, or treatment of a mental and/or behavioral health disorder (including a substance use disorder) in your home

I understand and agree that

- Medicare / major commercial insurances will **not cover or pay** for these telehealth services.
- No claims will be submitted to Medicare on my behalf.
- I may not rely on Medicare for reimbursement or payment of any kind.

Medicare Patient Int: _____

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4. Insurance Non-Reimbursement Disclosure (All Insurance Plans)

I understand and agree that **telehealth services provided by this practice are NOT eligible for submission to any insurance carrier**, including but not limited to:

- Medicare
- Commercial or private insurance plans
- Employer-sponsored health plans
- Health Sharing Insurances (Example: Medishare)

I acknowledge that **no claims will be submitted** to any insurance provider and that **insurance reimbursement is not available** for these services under any circumstances.

Int:_____

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5. Financial Responsibility & Self-Pay Agreement

I understand and agree that:

- All telehealth services are provided on a **self-pay basis only**.
- I am **solely and fully financially responsible** for all telehealth service fees.
- Payment is due in full at the time services are rendered.
- I may not submit these charges to my insurance carrier for reimbursement.

Int:_____

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6. Waiver of Insurance Claims and Appeals

I knowingly waive any right to submit claims, request reimbursement, or pursue appeals with any insurance carrier related to telehealth services provided by this practice. I understand there are **no exceptions, retroactive submissions, or appeals** available.

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7. Parent / Legal Guardian Consent (If Patient Is a Minor)

If the patient is under the age of 18, I certify that:

- I am the patient's **parent or legal guardian**.
- I have the legal authority to consent to telehealth services on the patient's behalf.
- I consent to the electronic transmission of the minor's protected health information as described above.
- I accept **full financial responsibility** for all telehealth services provided to the minor patient.
- I understand the minor must also be present at the time of the visit.

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8. Language, Understanding, and Voluntary Consent

I confirm that this document has been presented in a language I understand, or that interpretation services were offered. I have had the opportunity to ask questions and receive clarification. I understand the risks, benefits, and alternatives to telehealth services and voluntarily agree to all terms contained in this waiver.

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9. Acknowledgment/Signature and Notary Signature

Patient or Parent/Legal Guardian Signature: _____

Printed Name: _____

Relationship to Patient (if minor): _____

Date: _____

Provider / Practice Name: _____

NOTARY ACKNOWLEDGMENT

State of _____
County of _____

On this _____ day of _____**, 20____**, before me, the undersigned Notary Public, personally appeared _____, known to me or satisfactorily proven to be the person whose name is subscribed to this document, and acknowledged that they executed the same for the purposes stated herein.

Notary Public Signature: _____

Printed Name: _____

Commission Number: _____

Commission Expiration Date: _____

Notary Seal: