

**CONSENT FOR CARE**

I request that HealthFirst provide care to me. I authorize HealthFirst to examine and/or perform laboratory testing and/or provide treatment to me. I understand that Wisconsin state law requires HealthFirst to report certain communicable diseases.

I understand it is my responsibility to read all information including the package insert given to me by HealthFirst.

HealthFirst is a teaching facility and you may receive services from a student under the supervision of HealthFirst staff.

HealthFirst participates in research projects from time to time, and may use non-identifying personal health information for statistical purposes required for research.

HealthFirst is in compliance with the Health Insurance Portability and Accountability Act that protects your personal health information. If you would like a copy of our privacy practices you may ask for a copy, or find a copy on our website at [www.healthfirstnetwork.org](http://www.healthfirstnetwork.org).

If you would like a claim submitted to your insurance company we will need to photocopy your insurance card. If you are submitting to insurance, you must present your card at the time of visit.  If your services are submitted to your insurance company, the insurance company may request your records to determine if the claim will be paid.  If you decline to use your insurance at the time of visit, ***HealthFirst will not submit at a later date and discounts are not available once you choose to bill Insurance***.  If you have medical assistance/Family Planning Only Services you are required to present a valid card at each visit.

I agree to pay for my services in a timely way. I understand that my share of the cost of services is based on my income and family size. I agree that additional charges may be added to my billing following my appointment based on my lab results and need for additional testing of specimens. I therefore certify, under penalty of perjury, that the information about my identity and financial status is true, accurate, and complete. If my income or address changes, I agree to notify HealthFirst at or before my next visit.

**SUPPLIES BY MAIL CONSENT**

I authorize Healthfirst Network Inc. to send birth control pills, Nuvarings, condoms, emergency contraception, or other non-prescription products to me through the U.S. Postal Service when needed to an address of my choice. I take full responsibility for the products once they have been sent in the mail. Products cannot be returned and all charges are final. Healthfirst Network Inc. is not responsible for any lost/stolen products.

**INFORMED CONSENT FOR TELEMEDICINE SERVICES**

**Introduction**

Telemedicine involves the use of electronic communication to enable health care providers at different locations to share individual client medical information for the purpose of improving client care. Providers may include Nurse Practitioners, Nurses and Clinic Assistants. The information may be used for diagnosis, follow-up and/or education and may include any of the following:

* Client medical records
* Medical images
* Live two-way audio and video
* Output data from medical devices, sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of client identification and imaging data. These protocols will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

**Expected Benefits:**

* Improved access to medical care by enabling a client to remain in his/her clinic (or remote site) while the provider obtains test results and other medical information from other sites.
* More efficient medical evaluation and management.
* Obtaining expertise of a distant specialist.

**Possible Risks:**

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

* In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the provider.
* Delays in medical evaluation and treatment could occur due to deficiencies or failure of the equipment.
* In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information.
* In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgement errors.

**By signing this form, I understand the following:**

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researcher or other entities without my consent.
2. 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 care or treatment.
3. I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction, and may receive copies of this information for a reasonable fee.
4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My provider has explained the alternatives to my satisfaction.
5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas.
6. I understand that it is my duty to inform my provider of electronic interactions regarding my care that I may have with other healthcare providers.
7. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

I have read and understand the information provided above regarding telemedicine, and have discussed it with my provider, or such assistant as may be designated. And all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby authorize HealthFirst Network to use telemedicine in the course of my diagnosis and treatment.

**Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Staff Witness Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**