

TOMBALL REGIONAL

INTERNAL MEDICINE

ASSOCIATES

**If interested in our Tele-medicne services please
read and sign the
Tele-Medicine Information Page.**

**If you are a Medicare patient please also read and sign
the**

Advance Beneficiary Notice of Non-coverage

**(Medicare has stopped paying for this service although
some advantage plans will.)**

**Thanks for allowing us to adress your health care needs
We are here for any questions you may have.**

INTERNAL MEDICINE

ASSOCIATES

Medicine Information Document

Tele-Medicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

1. I understand that the same standard of care applies to a tele-medicine visit as applies to an in-person visit.
2. I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my health care provider present in the room.
3. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
 - a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the tele-medicine visit and make other arrangements to continue the visit.
4. I understand that I have the right to refuse to participate or decide to stop participating in a tele-medicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
 - a. I may revoke my right at any time by contacting Tomball Regional Internal Medicine Associates at 281-516-0212
5. I understand that the laws that protect privacy and the confidentiality of health care information apply to tele-medicine services.
6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
 - a. I understand that my insurance carrier will have access to my medical records for quality review/audit.
 - b. I understand that I will be responsible for any out-of-pocket costs such as co-payments or co-insurances that apply to my tele-medicine visit.
 - c. I understand that health plan payment policies for tele-medicine visits may be different from policies for in-person visits and may not be covered by my insurance.
7. I understand that this document will become a part of my medical record.

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to tele-medicine visits shared with me in a language I understand; and (3) am located in the state of Texas and will be in Texas during my tele-medicine visit(s)

Patient/Parent/Guardian Printed Name

Patient/Parent/Guardian Signature

Witness Signature

Date

A. Patient Name:

C. Identification Number:

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for D. _____ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Tele-medicine and Tele-heath services	These services are not covered by Medicare Since this office is not located in a rural under-served area	\$30 to \$150 depending on length of visit

WHAT YOU NEED TO DO NOW:

Read this notice, so you can make an informed decision about your care.

- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D. _____ listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

- OPTION 1.** I want the D. _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
- OPTION 2.** I want the D. _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.
- OPTION 3.** I don't want the D. _____ listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).

Signing below means that you have received and understand this notice. You may ask to receive a copy.

I. Signature:	J. Date:
---------------	----------

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.