

House Psychiatric Clinic, Inc
Telehealth Insurance Waiver

I understand that as a Medi-Cal beneficiary, I am able to use my insurance for telehealth services if I come to House Psychiatric Clinic and I am present in the office for my appointments. I am choosing to pay privately for my appointments in order to use Telehealth services away from the doctor's office.

Please initial here: _____

I understand that as a Medicare beneficiary, I am unable to use my insurance for telehealth services due to the location of HPC's office. I am choosing to pay privately for my appointments in order to use Telehealth services.

Please initial here: _____

I understand that my insurance will not be billed for my appointment, and that I will pay the amount due at the time the appointment is set to begin. I also understand that my insurance cannot be billed later on for my telehealth appointment, because it did not take place in my doctor's office.

Please initial here: _____

I understand that I can withdraw my consent to pay privately for my telehealth appointments at any time. I also understand that if I do withdraw my consent, I will need to be present in my doctor's office for my appointments.

Please initial here: _____

My signature below indicates I have read this agreement and agree to its terms.

Authorized Signature for Patient

Date

Patient Name (Please Print)