[INSERT PRACTICE
LOGO HERE]

Acknowledgement of Financial Responsibility

Virtual Care/Telehealth

Patient Name Printed:_____

Insurance Carrier:_____

I acknowledge that it has been explained to me that certain telehealth care services that I have requested may not be covered under the terms of my health insurance plan. I recognize that it is my responsibility to understand if my insurance benefits include telehealth, if virtual care is a service that I wish to utilize. I acknowledge that any fees, copayments, or other cost-sharing amounts resulting from telehealth care that have not been covered by insurance become patient financial responsibility. Furthermore, I understand that any non-covered telehealth charges are a choice that may result in patient financial responsibility.

To make alterations to this decision, I am aware that I may notify [INSERT PROVIDER NAME HERE] or office staff in person. However, I understand that I may not be able to retroactively alter insurance determinations or, as a result, any amount that has already been invoiced to me. I am aware that timely filing and other limitations are put in place by insurance plans and will make retroactive alterations impossible.

I understand that it is my responsibility to discuss any changes to my existing insurance and/or financial situation with [INSERT PROVIDER NAME HERE] and staff.

By my signature below, I acknowledge that I am voluntarily signing this statement, and that it is being signed prior to services being provided. By signing this form, I understand all charges, resulting from telehealth care, that are not paid for by insurance are my full financial responsibility.

_____ _____

Patient/Legal Guardian Signature Date

_____ _____

Witness Signature Date