Scottsdale Physicians Group
Telemedicine Program
7975 N Hayden Road, Suite D-354, Scottsdale AZ 85258
Office: 480.268.2670 Fax: 480.268.2671
Email: telemedicine@spg-md.com

Patient Name: _____

PATIENT RELEASE AND CONSENT

- ❑ I hereby authorize Scottsdale Physicians Group to directly bill Medicare or Medicaid (AHCCCS), and for my insurance company to make direct payments to Scottsdale Physicians Group.
- ❑ Scottsdale Physicians Group may obtain medical or other information necessary in order to process my claim(s), including determining eligibility and seeking reimbursement for medical supplies ordered.
- ❑ I am aware the Medicare may not pay for preventative medicine, routine physical, or screening test
- ❑ I am aware that I am responsible for any deductible, co-payment or any amount that is not covered by my insurance company for my telemedicine visit. I understand all health plans are not the same, and they do not always cover the same services. In the event my health plan determines a service to be "not covered" I will be fully financially responsible for the complete charge(s).
- ❑ I hereby authorize Scottsdale Physicians Group to release any information necessary to insurance carriers regarding by illness and treatments.
- ❑ I hereby authorize a copy of my insurance card and any other identification to be used to process insurance claims for the period of my lifetime, this authorization will remain in effect until revoked by me in writing.
- ❑ I hereby authorize Scottsdale Physicians Group to obtain any and all medical records that pertain to my health care and/or any pertinent Protected Health Information.
- ❑ I understand that telemedicine is the use of electronic information and communication technologies by a healthcare provider used to deliver services to an individual when he/she is located at a different location or site than I am.
- ❑ I understand that the laws that protect privacy and the confidentiality of medical information including (HIPPA) also apply to telemedicine.
- ❑ 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 effecting my right to future care or treatment.
- ❑ I understand that by signing this form that I am consenting to receive health care services via telemedicine.

Initial: _____ *Please note: There will be a $25.00 fee for no-show visits.

*If a patient is absent or unavailable for their confirmed visit then a fee will be billed to the patient account unless the patient is hospitalized at the time of service.

Patient name: _____

Signature: _____

Relationship to patient (If other than patient): _____

Date: _____

Please note new patients must fill out all forms completely before our initial home visit.

Please submit completed form to:
telemedicine@spg-md.com or Fax: 480-268-2671