Trifecta Medical Group: Primary Care & Pediatrics

Patient Consents (v2.0)

Welcome to Trifecta Pediatrics & Primary Care, a division of Trifecta Medical Group!

We look forward to addressing all of your and your family's health needs. We encourage your questions and participation in all aspects of your and your family's care.

This following document is comprised of three (3) sections: 1) Consent for Health Care Service 2) Consent for use of Health Information 3) Consent for telehealth.

Please make sure to read through this document in its entirety, mark each box appropriately, and insert your signature at the bottom.

1. Consent for Health Care Service

My (patient/client) signature on this form serves to authorize providers, their assistants and/or designees to administer treatment or services provided by Trifecta Medical Group to me or my child(ren) as noted on this consent form. This authorization includes, but is not limited to, medical services, diagnostic procedures, and other services or procedures, which my provider considers necessary and to which, in addition to this consent, I verbally agree. My and my child(ren)'s health care providers will discuss with me the risks, benefits and alternatives to recommended treatments. I understand that health care services may be rendered by qualified staff under supervision. I acknowledge that no promises or guarantees have been made to me regarding treatment or service rendered by the practice. *

2. Consent for use of Health Information

I hereby give my consent for Trifecta Medical Group (the Practice) to use and disclose my protected health information (PHI) or that of my legal minor(s) to perform treatment, payment and health care operations (TPO).
With this consent, the Practice may call me or email me to my home or other alternative location and leave a message by voice, email or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and anything pertaining to my clinical care, including laboratory test results.

With this consent, the Practice may mail to my home or other alternative location any items that assist the practice in performing TPO, such as appointment reminder cards, patient statements and anything pertaining to my clinical care as long as they are marked “Personal and Confidential.”

By signing this form, I am consenting to allow the Practice to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the Practice has already made disclosures upon my prior consent. If I do not sign this consent, or later revoke it, the Practice may decline to provide treatment to me. *

3. Telehealth/ Telemedicine Consent

If you or your legal minor(s) are going to have a clinical encounter using videoconferencing technology with a provider at Trifecta Medical Group, this consent must be signed.

You will be able to see and hear the provider and they will be able to see and hear you. Just as if you were in the same room.

Since 1994, the technology has connected tens of thousands of patients and providers in Kentucky.

The information may be used for diagnosis, treatment, therapy, follow-up and/or education.

Nurse Practitioners, physicians, and other medical personnel such as physician assistants and other types of providers such as registered nurses, speech-language pathologists, physical therapists, dieticians, psychologists, pharmacists, occupational therapists, optometrists, social workers, and behavioral analysts are called "providers" on this form.

The Process:

You will log on to a device of your choice to navigate to the internet. Please utilize the Doxy.me link that was emailed to you. No downloads or additional software is required.

Please log on to Doxy.me approximately 10 minutes prior to your scheduled telehealth appointment. If you are unsure of what is happening, you may ask questions of the provider. If you are not comfortable with seeing a provider on videoconference technology, you may reject the use of the technology and schedule a traditional face-to-face encounter when available. Safety measures are being used to ensure that this videoconference is secure, and no part of the encounter will be recorded without your written consent.

Possible benefits of Telehealth include:

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• Improved access to care. A patient can get services from anywhere in Kentucky.
• A patient can stay close to home, working with local healthcare providers to maintain continuity of care.
• Less time and expense for travel.

Possible issues with Telehealth include:

• A telemedicine exam may not give the information needed to make a clinical decision.
• Technology problems may delay medical evaluation and treatment for the telehealth visit.
• Security measures may fail, causing a breach of privacy of personal medical information. This is very rare.
• Telehealth does not provide direct treatment, including emergency care.
• Lack of privacy at the patient's location or because the patient may use a non-secured or shared device.
• Interruption of the visit due to local factors or technology problems.

I understand the originating site provider may provide certain services using telehealth technology, including transmission of images, video and audio that are encrypted for privacy. I understand that these images will be used for diagnosis, treatment or consultation, as well as for educational purposes only within Trifecta Medical Group.

By signing below, I understand the following:

1. This consent is in addition to any consent I gave for the care I or my legal minors are receiving.

2. This consent is for all the visits that include telehealth, and is valid for up to one year.

3. I am receiving telehealth services at the location of my choice, and I assume the risks that were discussed with me.

4. The laws that protect privacy and confidentiality of medical information also apply to telehealth. I have access to Trifecta Medical Group's Notice of Privacy Practices.

5. I have the right to withdraw my consent to the use of telehealth in the course of my care at any time. This will not affect my right to future care or treatment.

6. My provider will determine whether the condition being diagnosed or treated is appropriate for telehealth. If my provider believes I or my child(ren) would be better served by a traditional in-person office visit, he or she may at any time stop the telehealth visit and schedule an in-person visit for certain diagnosis and treatment or in the event of a technical failure.

7. No results are guaranteed or promised by using telehealth for care.

8. I or my insurance will be billed for telehealth services. I am responsible to Trifecta Medical Group for charges resulting from the services rendered using videoconferencing technology at their prevailing rates.

9. If my provider sees or hears anything that shows I have an emergency medical condition, he or she may call 911.

10. Law may require my provider to report certain events, such as self-neglect or if someone is in danger.

I have read and understand the information provided above regarding telemedicine, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my or my legal minor(s) care. I also consent to photographs of this video encounter being taken and stored in my patient file. *