[Provider Name/Clinic Name]
[Address]
[City, State, Zip Code]
[Phone Number]

Date: [Current Date]

Patient Name: [Patient Name]
Patient ID: [Account Number]

Telehealth Services Patient Financial Responsibility Statement

Dear [Patient Name],

This letter outlines your financial responsibilities regarding telehealth services provided by [Provider Name/Clinic Name]. Telehealth involves the use of electronic communications to enable health care providers at different locations to share individual patient medical data for the purpose of improving patient care.

Insurance Coverage and Verification:
It is your responsibility to verify with your insurance provider whether telehealth services are a covered benefit under your specific plan. While we may assist in verifying coverage, the final responsibility lies with you.

Co-payments, Deductibles, and Co-insurance:
Standard cost-sharing applies to telehealth visits. You are responsible for any co-payments, deductibles, or co-insurance amounts as determined by your insurance carrier. These amounts are due at the time of service or upon receipt of a billing statement.

Non-Covered Services:
If your insurance provider denies payment for telehealth services because they are deemed "not a covered benefit" or for any other reason, you agree to be personally and fully responsible for the total cost of the visit.

Technical Requirements:
You are responsible for ensuring you have the necessary technology (high-speed internet, webcam, and microphone) to participate in a telehealth session. Technical difficulties that prevent the completion of a visit may still result in a charge depending on the duration and nature of the interaction.

Cancellations:
Standard office cancellation policies apply to telehealth appointments. Failure to provide

[Number] hours' notice for a cancellation may result in a "No-Show" fee, which is not covered by insurance.

By signing below, you acknowledge that you have read, understood, and agree to the financial terms outlined above for telehealth services.

_____

Patient/Guarantor Signature

_____

Date