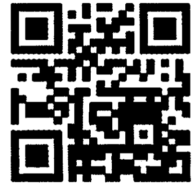

SCAN ME

Premier Primary Care Clinic LLC
11351 James Watt, El Paso Tx, 79936. Bldg C-300
Phone Number: (915) 320 - 7707
Email: Premiereprimarycare@gmail.com

Telemedicine: Telemedicine is the practice of medicine that uses technology to provide care from a distance . A doctor at one location uses a telecommunications infrastructure to provide care to a patient at a distant site. The American Academy of Family Physicians supports the expanded use of telemedicine as an appropriate and efficient means of improving health. During the evaluation, the provider will evaluate the patient using the following remote monitoring devices:

- **Digital Stethoscopes:** Allow enhanced listening and precision examination for providers of all types. By digitizing auscultation and ECG recordings, Eko helps providers easily store, analyze and share patients' heart and lung sounds.
- **Mobile Digital Otoscope** – Provides your doctor with high-quality digital images and videos of the ears to accurately diagnose the patient.
- **Kareo Telehealth** is the next generation HIPAA compliant video calling solution. Telehealth visits can be conducted on a computer or mobile device with up to 200 participants.

By signing below, I authorize Premier Primary Care Clinic to assess my child/dependent using telemedicine services

Parent/Guardian Signature ______________________ **Date** ____________

Student Information

First Name: ____________ **Last Name:** ____________ **Gender:** ☐ **Male** ☐ **Woman**

DateBirthBirth ____________ **Telephone:** ____________

Address: ____________ **City:** ________ **State:** ____ **Zip Code:** ________

Parent/Guardian Information

First Name: ____________ **Last Name:** ____________ **Gender:** Date of **:** ☐ **Male** ☐ **Female**

____________ **Telephone:** ____________

Email: ____________

Address: ____________ **City:** ________ **State:** ____ **Zip Code:** ________

Secondary Contact Information

Full Name: ____________ **Gender:** ☐ **Male** ☐ **Female** **Phone:**

____________ **Email:** ____________

By signing below, I certify that I have read and understand the above, have had the opportunity to ask questions and get answers, and agree to the above terms and conditions and agreed to pay all charges for which I may be legally responsible, including but not limited to deductibles, copays, and charges not covered by health insurance.

____

Parent/Guardian Signature

Payment Collection Form

I agree to be fully responsible for payment to Premier Primary Care Clinic LLC for this admission or any service if determined by my Insurance Plan(s) to be a non -covered service. I also understand and acknowledge that in the case of Out of Plan/Network services, there may be reduced benefits and I may be required to pay a larger co-payment, coinsurance, or other charge in the event my Insurance Plan(s) does not reimburse these services provided to patient.

Credit Card Authorization

I *agree to pay all charges for which I may be legally responsible including, but not limited to health insurance deductibles, co-payments, and non-covered.*

______________________________ ______________________________

Signature: Date:

Card Information

First name: ______________________________

Last Name: ______________________________

Card Number: ______________________________

CVV: ________________ Expiration Date: ________________