Consent to Participate in a Telehealth Consultation

1. **Telehealth**

Telehealth includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of protected health information, and education using synchronous or asynchronous audio, video, or data communications. I understand that my health care provider, through the Company (the "Company"). wishes me to engage in a Telehealth consultation with the Company. This means that I, or a designee, will, through an interactive video connection, or via telephone means if approved, be able to consult with a designated healthcare practitioner about my condition.

2. **Identity Verification**

I may be expected to provide a copy of my driver's license and other identity verifying documentation requested by the healthcare practitioner before any health services are provided.

3. **Privacy and Security of Communications**

All electronic communications between me and the healthcare practitioner will be transmitted using reasonable measures to ensure confidentiality. I will be responsible to secure and protect the functionality, integrity, and privacy of my hardware, files, and communication. Password protection for accessing my hardware and files is recommended. If others will be accessing the same computer, be aware that programs exist that copy every keystroke I make. It is recommended that I schedule my sessions with the undersigned healthcare practitioner when and where I can ensure the greatest level of privacy for all communications. Be sure to fully exit all programs and hardware at the end of each session. I explicitly waive confidentiality if there is another individual at my distant site I am using Telehealth at.

4. **Risks Associated With Distance Services**

There are privacy and security risks and consequences associated with Telehealth despite the policies and procedures in place to guard against them. The risks and consequences include, but are not limited to, interrupted or distorted transmission of data or information due to technical failures and access or interception of my protected health information by unauthorized persons.

By signing this information and consent form below, I acknowledge the limitations inherent in ensuring client confidentiality of information transmitted in Telehealth and agree to waive my privilege of confidentiality with respect to any confidential information that may be accessed by an unauthorized third party despite the reasonable efforts of the Company to arrange a secure line of communication.

My health care provider has explained to me how the video conferencing technology will be used.

I understand that this consultation will not be the same as a face-to-face visit since I will not be in the same room as the healthcare practitioner, and that some parts of a visit may be conducted by individuals present with me at the direction of the healthcare practitioner. I also understand individuals may be present at either location to operate the audio/video equipment and that these individuals must maintain the confidentiality of health information disclosed, or if they join I at my discretion, then confidentiality may be waived.

I understand there are possible risks of an incomplete or ineffective consultation because of the technology, and that if any of the risks occur, the consultation may terminate. The risks may include:

a. Failure, interruption or disconnection of the audio/video connection;

b. A picture that is not clear enough to meet the needs of the consultation;

c. A minor risk of access to the consultation through the interactive connection by electronic tampering.

I understand that in place of this Telehealth session I may seek face-to-face consultation with a health care provider.

I understand that I will not receive any royalties or other compensation for taking part in this Telehealth session or for the authorized use of any consultation images or audio.

I release the Company, its employees, agents and assigns from any and all liability which may arise from this Telehealth consultation, the use of interactive audio/visual connections, or from the taking or authorized use of any images or audio obtained.

5. Communication Interruptions

If I am unable to connect with the Telehealth platform or are disconnected during a session due to a technological breakdown, I will try to reconnect within 5 minutes. If reconnection is not possible the Company can be reached at the business phone number.

6. E-Mail and Text Messages

The undersigned healthcare practitioner may use and respond to e-mail and text messages only to arrange or modify appointments. Please do not send e-mails related to my treatment electronic communications are not completely secure and confidential. Any health related questions or issues will not be addressed by the healthcare practitioner in any electronic communication but will be dealt with during my next health session. Any electronic transmissions of information by me are retained in the logs of my service providers. While it is unlikely that someone will be

looking at these logs, they are, in theory, available to be read by the system administrator(s) of the service providers. I should know that any e-mails or any communications sent via Facebook, online and specifically the Company website are not secure, and I assume the risks of the insecure transmission.

7. **Audio and Video Recordings**

I acknowledge and, by signing this information and consent form below, agree that neither I nor the undersigned healthcare practitioner will record any part of my sessions unless I and the Company mutually agree in writing that the health session may be recorded. I further acknowledge that the Company objects to me recording any portion of my sessions without the Company's written consent. I expressly agree that audio and video recordings used for security or legal and documentation purposes are not part of my health records, and are therefore not protected by confidentiality or any other provisions under this agreement.

8. **Consent to Treatment Using Telehealth and Distance Health Services**

I voluntarily agree to receive synchronous (or asynchronous) assessment, care, treatment, and services through the use of email and texts and authorize the Company to provide such care, treatment, or services as are considered necessary and advisable. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

HOW AND WHEN TO DISCONTINUE TELEHEALTH SERVICES

Telehealth services and care may not be as effective as face-to-face services. The Company will continually assess the appropriateness of Telehealth for me. If the Company determines that I would be better served by receiving different services, such as face-to-face services, recommendations for treatment and treatment providers or facilities will be provided to me. I may also communicate to my provider that Telehealth services are no longer appropriate for me. My provider will consider patient safety (e.g., suicidality) and health concerns (e.g. viral risk; mobility; immune function), community risk, and the Healthcare Provider's health when deciding to do Telehealth services versus in-person.

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Patient/Representative Signature Date