MID-STATE HEALTH CENTER
101 Boulder Point Drive, Suite 1
Plymouth, NH 03264
P: 603-536-4000 | F: 603-536-4001
midstatehealth.org

Telemedicine: Consent to Treat, Guarantee of Payment, and Acknowledgement of Notice of Privacy Practices

Patient's Printed Name: _____ **DOB:** _____

I. CONSENT TO TREAT:

I, the patient identified below or the parent or legal guardian of the patient identified below (the "Patient"), consent to receive telemedicine services from Mid-State Health Center ("MSHC"). These services may include diagnostic procedure(s), treatments, and/or tests that the physician(s), nurse practitioner(s) or physician assistant(s) (each, a "Provider") determines to be necessary and advisable. The name, credentials, licensure/certification, and/ or qualifications of the Provider providing the telemedicine services is available upon request.

I understand that telehealth technology will be used to connect the Patient with a Provider, and that such consultations may be conducted by videoconferencing, video images, and/or by telephone conference as permitted by applicable law. I understand that MSHC has security measures sufficient to protect the Patient's electronic health information and, therefore, this information is not stored. MSHC uses password and authentication protections as additional safeguards where appropriate.

I understand that as part of the consultation process, my health condition may necessitate that the Provider obtain a photograph or image in certain situation (i.e., wound care). I consent and agree to the use of this image for treatment purposes and acknowledge that it may be necessary when providing quality healthcare services via telehealth technology. I understand that all or a part of the image may become part of the medical record.

I understand there may be potential risks, benefits and alternatives to telemedicine and choose to proceed with a telemedicine consultation. I hereby release and hold harmless MSHC from any loss of data or information due to technical failures.

In choosing to participate in a telemedicine appointment, I understand that the use of telemedicine technology for diagnosing or treating health conditions presents certain risks, including but not limited to the following, which may occur in rare instances:

- Transmitted information may be distorted or insufficient to allow for appropriate medical decision making;
- There may be unanticipated delays in diagnoses or treatments due to equipment or technology failures or deficiencies;
- Should the Provider have limited access to the complete medical records due to the above situations, this may result in adverse drug interactions, allergic reactions, or other medical decision errors;
- Records of services provided may be lost through technical failures; and
- In rare cases, security protocols could fail, causing a breach of privacy of personal medical information.

In the event of an adverse reaction to treatment or if there is a telemedicine equipment failure, I understand that I may choose to re-initiate telemedicine services through the Ring Central platform per instructions provided by MSHC. I understand that should I choose to contact MSHC rather than re-initiate the call, that I may be instructed to seek additional treatment during an office visit, at MSHC's Same-Day Service, an Urgent Care facility, or Emergency Department as appropriate under the circumstances.

I also understand that the Provider may terminate the telemedicine appointment if he or she feels the service is inappropriate to evaluate the current condition and may direct the me to an alternate care service (i.e., Emergency Department, Urgent Care, or Specialist), as appropriate and in the Provider's sole discretion. I

acknowledge that the Provider's responsibility to provide medical services will end upon termination of the telemedicine visit.

I understand that I have the right to terminate the telehealth appointment at any time, without affecting the right to future care or treatment.

I acknowledge that in cases where there is a disclosure of intent to harm to self or others, or instances of past or present child neglect or abuse, disclosure and/or mandated reporting may result in accordance with applicable local, state or federal law and/or MSHC's policies and procedures.

I authorize MSHC to retrieve and store relevant treatment history through a health information exchange as permitted by state law and to use and disclose PHI as permitted under the Health Insurance Portability and Accountability Act ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act ("HITECH"), other applicable law, and by MSHC's Notice of Privacy Practices. I understand that I may choose to opt out of the health information exchange, pursuant to applicable state law.

I understand that I will have access to the telemedicine records through MSHC's Patient Portal. I may obtain copies of such records from the Patient Portal for my own use. Alternatively, I may request a copy of my medical records by emailing medicalrecords@midstatehealth.org or by calling (603) 536-4000.

Telehealth Visits for Adolescent during School Hours

I understand that, in some instances, such as when the Patient is in school or elsewhere, such telemedicine services may be provided to the Patient without the Patient's parent or legal guardian being present. I further understand that the Provider will not prescribe to the Patient any new medications or controlled substances under federal law, without consulting and getting informed consent of the parent or guardian.

I understand that should the parent or guardian not be present, some adolescent Patients may need assistance from a school nurse, facilitator, or other adult who is not employed by or affiliated with MSHC to help coordinate the telehealth visit. In such instances, I understand that these people may be privy to protected health information ("PHI") in order to assist the Patient, and may remain in the area if necessary, to aid in the visit. I agree that MSHC will not be held responsible for medical care, services, and treatment delivered before or after the telehealth visit by any persons (i.e., nurses, facilitator, or teacher) not employed by MSHC.

In instances where the telemedicine visit is conducted on school grounds, I hereby give permission and consent for the school nurse or other representatives of the school to release and exchange information about the Patient's health history or other confidential personally identifiable information about the Patient to MSHC to aid in the telemedicine treatment. I acknowledge that there may be information provided to MSHC that may be considered education records that are subject to the Family Educational Rights and Privacy Act ("FERPA"). I understand that MSHC will comply with any applicable FERPA or state law requirements regarding the confidentiality of education records that it may come to possess.

II. RELEASE OF INFORMATION: I hereby consent to the use and disclosure of the Patient's PHI for purposes of treatment, payment and to facilitate MSHC's health care operations as described in the Notice of Privacy Practices. I hereby authorize and direct MSHC to release to government agencies, insurance carriers, managed care companies, or other entities who are or may be financially liable for the Patient's medical care (and to authorized agents of such entities) all information needed to substantiate payment for this medical care and to permit representatives thereof to examine and request copies of records related to the Patient's case and medical treatment. I further authorize MSHC to release billing information to any healthcare provider the Patient chooses or who may be involved in the Patient's care.

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III. ASSIGNMENT: I hereby assign, transfer and set over to MSHC sufficient monies and/or benefits to which I am or may be entitled from government agencies, insurance carriers, or others who may be financially responsible for the Patient's medical care to cover costs of the care and treatment rendered.

IV. PATIENT GUARANTEE OF PAYMENT: I accept that I am financially responsible for all services rendered on the Patient's behalf for which a charge may be associated. I accept personal responsibility for all co-payments, deductibles, and non-covered services, as dictated by my or the Patient's insurance coverage (hereinafter, the "insurance plan"), plus any collection costs for amounts personally owed by me. I acknowledge that there may be services provided by MSHC that may not be covered by the insurance plan for one or more reasons, including but not limited to exclusions under the insurance plan, exhaustion of benefits, the insurance plan's designation of MSHC as an out-of-network provider, and/or my failure to provide the insurance card. I understand that if I do not fulfill the requirements of the insurance plan, do not receive the requisite prior approval, if the authorization is denied, or if the insurance plan refuses to pay the cost of the telemedicine services for any other reason, I understand and agree that I am financially responsible for the cost of these services.

If the insurance plan sends me, or the Patient, money that is designated to pay for the services provided by MSHC, I agree to send the check or an amount equal to the amount received by the insurance plan to MSHC. I understand that all bills are to be paid immediately upon receipt. Should a medical bill create an unexpected financial hardship, I will contact MSHC for agreeable payment arrangements. I also understand that in the event my account is transferred to a collection agency due to my failure to pay for services, that I will be responsible for any reasonable attorney's fees and collection fees incurred by MSHC in collecting payment, in addition to the amount of the bill.

V. HIPAA ACKNOWLEDGEMENT: I understand that MSHC has a Notice of Privacy Practices that contains a description of the uses and disclosures of my health information, and that I have received a copy of this Notice. I further understand that MSHC may update its Notice of Privacy Practices at any time, and that I may receive an updated Notice of Privacy Practices by submitting a request in writing to MSHC or by accessing the most current Notice of Privacy Practices online at www.midstatehealth.org.

VI. AFFIRMATION: I affirm that I have read and fully understand this Telemedicine Consent to Treat, Guarantee of Payment, and Acknowledgement of Notice of Privacy Practices form and have been given the opportunity to ask questions and that all my questions have been answered to my satisfaction.

_____ _____
Patient's Signature: Date:

_____ _____ _____
Legal Representative's Printed Name: Legal Representative's Signature Date:

_____
Authority/ Relationship of Representative to Patient

Revised: 10/06/20 rje/ ab