Telehealth is healthcare provided by any means other than a face-to-face visit. In telehealth services, medical, mental health, and substance abuse information is used for diagnosis, consultation, treatment, therapy, follow-up, and education. Health information is exchanged interactively from one site to another through electronic communications. Telephone consultation, videoconferencing, transmission of still images, e-health technologies, patient portals, and remote patient monitoring are all considered telehealth services.

Telehealth may be referred to as Telemedicine or Telepsychiatry.

Patient's Initials

_____ I understand that telehealth involves the communication of my medical/mental health/substance abuse information in an electronic or technology-assisted format.

_____ I understand that I may opt out of the telehealth visit at any time. This will not change my ability to receive future care at this office.

_____ I understand that telehealth services can only be provided to patients, including myself, who are residing and physically located in the state of NORTH CAROLINA at the time of this service.

_____ I understand that I am personally responsible for associated visit charges. Payment to the provider is required at the beginning of each telehealth session in the form of credit or debit card. The provider's private practice does not accept insurance.

_____ I understand that all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include but are not limited to:

- It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures.
- Electronic systems that are accessed by employers, friends, family or others are not secure and should be avoided. It is important for me to use a secure network.
- Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures.

_____ I agree that information exchanged during my telehealth visit will be maintained by the provider and healthcare facilities involved in my care utilizing paper and electronic healthcare approved tools.

_____ I understand that medical information, including medical records, are governed by federal and state laws that apply to telehealth. This includes my right to access my own medical records (and copies of medical records).

_____ I understand that the company selected to conduct my telehealth visit is an independent company specializing in HIPAA compliant telemedicine. My provider has no responsibility for that company's operations or security of my protected health information. In addition, the company might

send me emails or communication. I understand that the provider is not responsible for this communication. If I am receiving any unwanted communication from the company, I will call/contact the company directly and address my concerns with them. I understand important emails from the company could include reminder or information for telehealth visits scheduled with the provider.

_____ I understand that I must take reasonable steps to protect myself from unauthorized use of my electronic communications by others.

_____ The healthcare provider is not responsible for breaches of confidentiality caused by an independent third party or by me.

_____ I agree to inform my provider if any other person can hear or see any part of our session before the session begins.

_____ I agree that I will not record any part(s) of my telehealth visits without written consent from my provider.

_____ I agree that I have verified to my healthcare provider my identity and current location in connection with the telehealth services. I acknowledge that failure to comply with these procedures may terminate the telehealth visit.

_____ I understand that I have a responsibility to verify the identity and credentials of the healthcare provider rendering my care via telehealth and to confirm that he or she is my healthcare provider.

_____ I understand that I, not my provider, am responsible for the configuration of any electronic equipment used on my computer/tablet/phone for my telehealth services. I understand that it is my responsibility to ensure the proper functioning of all electronic equipment before my session begins.

_____ I understand and agree that an evaluation via telehealth may limit my healthcare provider's ability to fully diagnose and/or treat my conditions. As the patient, I agree to accept responsibility for following my healthcare provider's recommendations—including further diagnostic testing, such as lab testing and/or urine drug testing, referral recommendations, or an in-office visit.

_____ I understand that telehealth sessions will provide a different experience compared to an in-office visit. I understand there could be some technical problems (video or voice quality, internet connection) that may affect the telehealth session and affect the decision-making capability of the provider

_____If my healthcare provider feels urine drug testing is needed to safely prescribe me a controlled substance, or as part of my treatment plan, I agree to go to the location to where I am referred for testing. I understand that my provider may decline any request for a controlled substance, or other prescription, if he/she has concerns during a telehealth visit and may require an in-office visit for further clinical evaluation.

_____ I understand that telehealth appointments with the provider are scheduled in advance, in keeping with her usual office hours, and pending her availability.

_____ I understand that the provider may offer or require telehealth appointments for various reasons. These include, but are not limited to, efforts to comply with federal or state mandates, national or state emergency guidelines, isolation and social distancing practices. Established patients in the provider's private practice may qualify.

_____ I understand that telehealth appointments with the provider have the same cancellation policy as scheduled, in-office appointments. No shows and cancellations of less than 24 hours are billed at the full scheduled appointment fee and must be paid before the next scheduled telehealth or in-office appointment.

_____ I understand that electronic communication may be used to communicate highly sensitive medical information, such as treatment for or information related to HIV/AIDS, sexually transmitted diseases, or addiction treatment (alcohol, drug dependence, etc.).

_____ I understand that my healthcare provider may choose to forward my information to an authorized third party. Examples include, but are not limited to, use of email address for appointment reminders, contact information for billing providers, and to fulfill authorized releases. Therefore, I have informed the healthcare provider of any information I do not wish to be transmitted through electronic communications. I understand that certain sharing or information may be required for telehealth services.

_____ By signing below, I understand the inherent risks of errors or deficiencies in the electronic transmission of health information and images during a telehealth visit.

_____ I understand that there is never a warranty or guarantee as to a particular result or outcome related to a condition or diagnosis when medical care is provided.

_____ To the extent permitted by law, I agree to waive and release my healthcare provider and his or her practice from any claims I may have about the telehealth visit.

_____ I understand that the provider does not provide evaluation or treatment for medical or psychiatric emergencies using telehealth.

_____ I understand that electronic communication should never be used for emergency communications or urgent requests. If I have an emergency, I should contact the existing emergency 911 services or my county's 24-hour mental health crisis line or go to my nearest emergency room.

_____ ***I understand that the provider communicates with patients as-needed outside of scheduled appointments by phone only. The provider does not monitor or respond to emails, text, chat, or unscheduled "walk-ins" to the virtual waiting room.***

I certify that I have read and understand this agreement and that all blanks were filled in prior to my signature with the opportunity to have questions answered to my satisfaction. I hereby consent to engaging in telehealth services and/or electronic communication

between ____Heidi Green, MD___ (Provider's Name) and

_____
Patient's Printed Name

_____ _____
Patient's Signature Date/Time

I certify that I have explained the nature of this agreement to the patient. I have answered all questions fully, and I believe that the patient fully understands what I have explained.

_____ _____
Provider's Signature Date/Time