

TELEMEDICINE SERVICES & INFORMED CONSENT WITH DR. FOUST

Thank you for considering telemedicine option for your mental health care and wellbeing. The age of the Internet continues to facilitate new ways to assist people to meet their healthcare requirements and I am happy to move in step with technological advancements. As part of my commitment to your wellbeing and safety, there are a few statutory and consumer guidelines that must be followed. This includes an informed consent, both for the use of Telemedicine as well as the storing of payment information and the recurring charge for such services.

Definitions:

YOU and YOUR: mean the patient or the patient's legal representative. In the event, for any treatment that is for a child, both parents are required to initial and sign, unless shown that one parent has sole legal custody AND medical decision-making.

Clinician: A therapist authorized by licensure to practice mental health therapy.

HIPAA/PHI: Health Insurance Portability Act and Personal Health Information, both of which are governed both by State and Federal laws.

Services: Mental Health Therapy and other psychotherapeutic forms of therapy, including, but not limited to testing, EMDR, hypnosis, play, mediation, and any other services designed to fit the purpose of the patient's treatment.

Telemedicine: Telemedicine is the use of electronic transmissions to treat the needs of a patient. In this case, I offer both video and audio forms of communication via the Internet and/or telephone. This means the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications.

INFORMED CONSENT

By selecting and signing below, you acknowledge that there are logistical and privacy issues that may or may not be compromised in the use of such systems. We will continue to abide by the HIPAA/PHI standards you have received as part of your Initial Intake Packet. However, please read the following and initial following each section to show your understanding:

- (1) YOU, "the patient", or YOUR legal representative," retain the option to withhold or withdraw consent to telemedicine at any time without affecting the right to future care or treatment nor risking the loss or withdrawal of any program benefits to which YOU or YOUR legal representative would otherwise be entitled.

Initial(s): _____

- (2) The risks involved with Telemedicine include the potential release of private information due to the complexities and abnormalities involved with the Internet. Viruses, Trojans, and other involuntary intrusions have the ability to grab and released information you may desire to keep private. Furthermore, there is the risk of being overheard by anyone near you if you do not place yourself in a private area and open to other's intrusion. The advantages of Telemedicine include the benefit of continuity of care in the absence of your clinician as well as the ability to be treated from any location at any time. It is YOUR responsibility to create an environment on your end of the Telemedicine transmission that is not subject to unexpected or unauthorized intrusion of your personal information. It is MY responsibility for the clinician to do the same.

Initial(s): _____

(3) All existing confidentiality protections apply as noted in your HIPAA/PHI information portion of your Initial Intake Packet.

Initial(s): _____

(4) All existing laws regarding patient access to medical information and copies of medical records apply.

Initial(s): _____

(5) Dissemination of any patient identifiable images or information from the telemedicine interaction to researchers, individuals, physicians, or other persons and entities shall not occur without YOUR consent.

Initial(s): _____

(6) YOU acknowledge that you have both received a copy of this Consent form and have given both written and verbal consent to utilizing Telemedicine as part of your treatment.

Initial(s): _____

(7) The written consent statement signed by YOU or YOUR legal representative shall become part of YOUR medical record.

Initial(s): _____

(8) The failure of any health care practitioner to comply with the above shall constitute unprofessional conduct.

Initial(s): _____

(9) All existing laws regarding surrogate decision making shall apply. For purposes of this section, ,,,"surrogate decision making" means any decision made in the practice of medicine by a parent or legal representative for a minor or an incapacitated or incompetent individual.

Initial(s): _____

(10) Dr. Foust has agreed to provide tele health services at my request and as a result is indemnified from any breach of confidentiality issues or insurance issues as I assume complete responsibility for them.

BILLING, PAYMENT AND OTHER SUBSCRIPTIONS

I offer my clinical services for a fee. All fees are stated in U.S. dollars unless otherwise specified.

A. Payment by Credit Card.

When you provide credit card information, you represent that you are the authorized user of the credit card that is used to pay for our services or other fees and authorize me to charge your credit card for any services or other fees incurred by you. For recurring monthly services, each month that you use such service(s), you agree and reaffirm that I am authorized to charge your credit card for the service fee. You agree to notify me promptly of any changes to your credit card account number, its expiration date and/or your billing address, and you agree to notify me promptly if your credit card expires or is canceled for any reason.

B. Charges to Your Credit Card.

ALL SERVICE FEES ARE PAYABLE IN AT THE TIME OF SERVICES AND ARE NOT REFUNDABLE IN WHOLE OR IN PART. I reserve the right to change fees or billing methods at any time and will provide notice of any such change at least thirty (30) days advance. All

changes will be posted as amendments to this Agreement and you are responsible for reviewing the billing section of this agreement to obtain timely notice of such changes. Your non-cancellation of your treatment thirty (30) days after posting of the changes means that you accept such changes. If any change is unacceptable to you, you may cancel your treatment at any time as described below, but SDFS will not refund any fees that may have accrued to your account before cancellation of your treatment, and I will not prorate fees for any cancellation.

As the patient, or the patient's legal representative, you are responsible for all charges incurred, including applicable taxes, and all payments made by you or your authorized legal representative. I will protect any and all credit card payment information and may require your re-authorization from time to time via email. You agree that email consent is valid and providing the CID/CCD code associated with your card within your email is confirmation of the valid consent. In other words, we will send an email requesting authorization to charge your card for the services rendered. Your response with an affirmative and providing your CID/CCD number within the email serves as valid confirmation to charge your card.

METHOD OF TELEMEDICINE

Be sure to have my contact number in the event your video conferencing is interrupted or unavailable at the time of your session.

Video Conferencing - Skype:

I will have my computer on and Skype service available. It is your responsibility as the patient to log in and request a session via Skype at your scheduled time or up to 2 minutes prior. The Skype name for me is: _____.

If you are unfamiliar with Skype and are a new user, go to <http://www.skype.com> to download the software. After installing the software, look for the "add contact" in the upper left hand corner of your screen. Type in my Skype name and it will request that I be added. I will confirm at some point prior to your session and then I will be added as a contact in your contacts section. This operation is only required once. The next time you log in, you will merely click my name and a new dialogue screen will come up. Please note that there are a few icon symbols to be aware of: "Offline"; "Online"; "Away"; "Do Not Disturb". If you see that my setting is "Online", click the green button "video call", and that will ring her to start your session. I will accept your request when it's time for your session. **Please do not make a call if you see that the "do not disturb" icon is showing next to her name.**

A few glitches to be aware of:

Be sure that there is plenty of light at your location and that your camera allows your face to be seen.

If your internet connection is slow, there will be problems with feedback or a broken connection. Where possible, be directly connected to your internet modem or be so close to your wireless connection that you have full signal. Also, do not use dial up. Please upgrade to DSL or Cable. If you have multiple programs running while you are in a Skype session, your computer might become overloaded and the connection can become spotty or broken. Please shut down all other programs prior to starting the Skype program.

Using a headset is often better than using the computer speaker and microphone, and more private. Most all computers have the necessary jacks to allow a headset plug in.

Please have some patience. Technology continues to get better, but it is still imperfect. If the Skype session is unable to be utilized after two or three attempts, be open to having a phone session for that time. Also, if the connection becomes broken and lost, reconnect and carry on from where you left off.

Lastly, I am investigating all video call options and if there is another, more stable, program that we can use, we will inform everyone at that time. Be flexible and understanding in the beginning

as we move to this technology on a more regular basis. The age of telemedicine is here and I appreciate your desire and willingness to take it on.

Telephone:

It seems almost unnecessary to inform how to use the telephone as a method for Telemedicine. However, some of the same procedures apply, including, calling me when your session is expected. A window of two minutes prior to twenty (20) minutes after will be held open for your call. If you call more than twenty (20) minutes after your scheduled time, I may or may not be available to answer and the session will be considered a “no-show” and be charged in accordance to office policies and procedures stated within your Initial Intake Packet.

For your session, remember to be in a place that you feel comfortable speaking about personal, confidential, and private information. If you are using a cell phone, remember that not all calls or phones are considered absolutely secure and may be compromised through various detection devices. You agree, however, that the use of cell phones is an appropriate method of Telemedicine by initialing here: _____. If you do not initial, then you agree that you will always use a landline and I will do the same.

Protocols to follow include only using first names when addressing others or when being addressed. In addition, utilizing pet names or nick names for people in your life you wish to discuss will further disguise your identity and the identity of others in the event someone is attempting to listen to your Telemedicine session.

ACKNOWLEDGMENT OF WHICH METHOD OF TELEMEDICINE TO USE

I/We, _____, have read the above mentioned Telemedicine Services and Informed Consent and have chosen the following method of Telecommunication in the event that I/We schedule to speak to you via Telemedicine:

____ Video Conference (Via Skype or other form available to me)

____ Telephonic

____ No preference

____ I do not wish to participate

I/We understand that there are both risks and benefits as mentioned within this consent form as well as others that I/We may not fully be aware of that can occur with or without our knowledge. I/We understand that (clinician) will use best efforts to conceal personal information and abide by HIPAA/PHI standards. I/We will use our best efforts to be in a location that facilitates a private conversation, free from interference or involuntary divulging of my personal information.

I/We understand that (clinician) does not consider the use of cell/mobile phone texting, email, or other electronic methods other than the aforementioned, to be covered under the Telemedicine Services and Informed Consent agreement. In the event I/We use this method to communicate at any time, I/We understand that there are no protocols or protective standards and that such communication will be limited in nature and at the sole discretion of the clinician as to its content or duration. I/We will hold _____(clinician and employees, harmless and free from liability in the event I/We use this method of communication and engage (clinician) to receive communication in this manner.

I/We agree that we have been verbally informed in addition to this written informed consent regarding the use of Telemedicine as a means of facilitating My/Our therapy sessions.

Signature Date

Patient: _____

Signature Date

Patient: _____

Signature Date

Clinician: _____

REVOCAION OF TELEMEDICINE AUTHORIZATION:

In the event you decide to revoke your authorization and informed consent, please complete the following and fax it to _____. It will be placed in your file.

I/We, _____, revoke our prior authorization and informed consent to use Telemedicine as a means of therapy. I/We further understand that in the event I/We use Telemedicine after this revocation and fail to inform our clinician of our revocation, then such revocation shall become null and void and a new revocation will be required.

Signature _____
Date _____

Patient: _____

Signature _____
Date _____

Patient: _____