Consent to Participate in Telemedicine Consultation

1. My health care provider and I wish to engage in a telehealth consultation.
2. I understand that telehealth sessions typically last approximately 40 minutes due to limitations of the telehealth software.
3. My health care provider has explained to me how the video conferencing technology will be used and that such a consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.
4. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
5. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes.
6. I have had the alternatives to a telemedicine consultation explained to me.
7. I had the opportunity to ask questions in regard to this procedure.
8. I understand that my insurance may not cover services provided via telehealth. I agree to leave a credit card on file to pay the fees for service.
9. I have the right to refuse any procedure or treatment.
10. I have the right to discuss all medical treatments with my provider.

_______________________________________ ________________

Patient's/parent/guardian signature Date

Patient Name:

At my request Carter Psychology Center will be providing services and may bill my insurance. I authorize Carter Psychology Center to charge fees not paid at the time of service, including fees for services and those for late cancellation or no show, and not covered by my insurance policy to my credit card provided herein. I agree that I will pay for these purchases in accordance with the issuing bank's cardholder agreement.

Limited Credit Card Authorization Form

All information will remain confidential.

Cardholder Name: ____

Billing Address: ____

(city)________________________(state)___________(zip)_____________

Credit Card Type: _____ Visa _____ Mastercard ____ Discover ____ Amex

Credit Card Number: ____

Expiration Date: ____

Card Identification Number (last 3 digits located on the back of the credit card): ________

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Cardholder Signature

Patient Name:

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective date: April 10, 2003

If you consent, the provider is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination, test results, diagnosis, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Examples of uses of your health information for treatment purposes are:

- An employee of the provider's office obtains treatment information about you and records it in a health record
- During the course of your treatment, the provider determines that he/she will need to consult with another specialist in the area. He/She will share the information with such specialists and obtain his/her input.

An example of use of your health information for payment purposes:

- We submit a request for payment to your health insurance company. The health insurance company requests information from us regarding services rendered. We will provide that information to them about you and the care you receive.
- We verify insurance coverage prior to your first appointment and obtain prior authorization and precertification when required to do so by your policy coverage.

An example of use of your health information for health care operations:

- The state licensing authority wants to review records to assure that we have acted consistent with state law regarding your care. In doing so, it wants to take a sampling which includes review of your chart. At the licensing authority's request, we will provide it with a copy of your chart.

Your health information rights:

The health record and billing records we maintain are the physical property of this office. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your protected health information by delivering the request in writing to our office. We are not required to grant the request, but we will comply with any request granted.
- Obtain a paper copy of the Notice of Privacy Practices for Protected Health Information by making a request at our office.
- Request that you be allowed to inspect and receive a copy of your health record and billing record. You may exercise this right by delivering the request in writing to our office using the form we provide to you upon request.
- Appeal a denial of access to your protected health information except in certain circumstances.
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office using the form we provide to you upon request
- File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office using the form we provide to you upon request. The accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request.
- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office using the form we provide to you upon request.
- Revoke any authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

You have the right to review this Notice before signing the consent authorizing use and disclosure of your protected health

information for treatment, payment, and health care operations purposes.

If you want to exercise any of the above rights, please contact : Michael Spellman at 239-278-3443 In person, or in writing, during normal business hours. He/She will provide you with assistance on the steps to take to exercise your rights.

Our Responsibilities

The provider is required to:

- Maintain the privacy of your health information as required by law
- Provide you with a notice as to our duties and privacy practices as to the information we collect and maintain about you
- Abide by the terms of this Notice
- Notify you if we cannot accommodate a requested restriction or request
- Accommodate your reasonable requests regarding methods to communicate health information to you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice to reflect these changes. You are entitled to receive a revised copy of the Notice by calling or requesting a copy of our Notice or by visiting the office to obtain a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact the following person: Michael Spellman at 239-278-3443 You may also file a complaint by mailing or e-mailing it to the Secretary of Health and Human Services at 202-619-0257 We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from our office. We cannot, and will not, retaliate against you for filing a complaint with the Secretary.

Other Uses and Disclosures

- We have Business Associates with whom we may share your protected health information.
- For example, in preparing our annual financial statement, auditors may need to review samples of medical care given. We may disclose your health information to the accounting firm to prepare this material.
- For example, during our routine health care operations, we may need to hire computer technicians and software vendors. We may disclose your health information to these vendors to maintain daily functioning in our health care operations.

Notification

Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other persons responsible for your care, about your location, about your general condition, or your death.

Communication with Family

Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Disaster Relief

We may use and disclose your protected health information to assist in disaster relief efforts.

Funeral Directors/Coroners

We may disclose your protected health information to funeral directors or coroners consistent with applicable law to allow them to carry out their duties.

Marketing
We may contact you to provide you with appointment reminders, with information about treatment alternatives, or with information about other health-related benefits or services that may be of interest to you.

Fund Raising

We may contact you as part of a fund raising effort.

Workers Compensation
If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Public Health
As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Abuse and Neglect
We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Correctional Institutions
If you are an inmate of a correctional institution, we may disclose to the institution or agents there of your protected health information necessary for your health and the health and safety of other individuals.

Law enforcement
We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.

Health oversight
Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings
We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order.

To avert a serious threat or health or safety, we may disclose your protected health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.

For Specialized Governmental Functions
We may disclose your protected health information for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.

Other uses
Other uses and disclosures in addition to those identified in this Notice will be made only as otherwise authorized by law or with your written authorization and you may revoke that authorization as previously stated.

Website
We may maintain a website that provides information about our business. This Notice is on the website.

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Signature

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy.

Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a “friendly” version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services.

HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care.

Additional information is available from the U.S. Department of Health and Human Services.www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient’s condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I have read and understand this document

____
[signature]