

TELEMEDICINE SERVICES AGREEMENT FOR INDIVIDUAL AND GROUP VIDEO PARTICIPATION

Thank you for considering the use of telemedicine in support of your healthcare needs. While a “virtual” visit is similar in many ways to an “in-person” visit, there are some differences. To help ensure that your telemedicine experience fulfills your needs and expectations, the following terms and conditions apply:

A. CONSENT

Your participation in telemedicine is always voluntary, and you may stop participation at any time. If you choose not to participate in telemedicine, it will not affect any future care, services, or benefits to which you are entitled.

B. PATIENT PRIVACY

The same laws that protect the confidentiality and privacy of protected health information (PHI) and medical information, such as the Health Insurance Portability and Accountability Act (HIPAA), also apply to telemedicine services.

Just as with in-person visits, you have the right to access your medical information and the ability to obtain copies of your medical records related to your telemedicine visit.

C. PARTICIPATION RESPONSIBILITIES

1. Individual Telemedicine Services

During your telemedicine visit, you should be in a private location with good internet connection that is safe and appropriate for the provider to conduct your visit.

If you, your provider or a Stormont Vail Health team member has concerns about the quality of the internet connectivity or the safety or privacy of the environment that you appear to be in, the appointment may be rescheduled for another time and/or an “in person” visit may be requested.

2. Group Telemedicine Services

Every person participating in a group telemedicine visit has the right to privacy and confidentiality. As a means to respect the rights of everyone participating in a group session, the following conditions apply. Failure to comply with these conditions may result in termination from participation in group telemedicine sessions, and may result in civil liability for violating the privacy rights of any or all of the group participants:

- Each patient participating in group telemedicine retains their right to their personal privacy and privacy related to their PHI as discussed above;
- In accordance with the above described privacy rights and protections, participants in group telemedicine may not discuss, share nor disclose any information obtained or learned during a group session about another patient, including but not limited to names, treatments, occupations, or other personal information, such as stories they share, without the prior express consent of the patient providing such information;
- In order to protect the privacy of all patients participating in group sessions, the following expectations apply to all telemedicine group sessions:
 - > Participation must be conducted in a private area controlled by the participant, away from others and may not, under any circumstances, be conducted in a public site such as a library, coffee shop, etc.;
 - > Headphone/earbuds or other similar audio controlling devices must be utilized by the participant, where appropriate, to ensure that group telemedicine conversations are not inadvertently heard by others;
 - > Where required by the provider conducting the group session, video cameras facilitating the session must be activated and turned on throughout the entire session to allow all participants and facilitators to visually see and engage with one another;
 - > Each participant’s microphone must be muted and remain on mute until such time as it is the participant’s turn to speak or appropriately engage in the group discussion;
 - > Participants must dress appropriately, broadcast from a location that provides and maintains a conducive environment for telemedicine services (e.g., no background effects, noises, etc. that would be disruptive or detractive), at all times be respectful and engage in a manner that promotes and facilitates the goals, objectives and healthcare treatment being offered and administered through group interactive telemedicine services; and

> Participants, other than facilitators, are prohibited from conducting any type of recording (video, audio, tape, screen shots, written, etc.), regarding any aspect of a group session, and may not forward or disclose any session's participation invitation (including date, time, log-in and access information) to any other individual(s), without the prior express authorization of the session's healthcare provider/facilitator.

D. RISKS

As telemedicine involves the use of interactive audio, video and/or data to transmit oral and visual communications, and is reliant on technology, it is possible that a visit could be disrupted or distorted by technical issues/failures or interrupted or accessed by unauthorized persons, despite reasonable efforts by Stormont Vail Health.

Additionally, certain signs and symptoms that might be detected during an "in-person" physical examination may not be detected during a telemedicine visit due to the limitation of technology to produce the comprehensive assessment obtained through touch, auscultation, and other cues.

It is understood that there are potential risks and benefits associated with any form of treatment, both in-person and virtual, and that no results can be guaranteed or assured.

E. FINANCIAL

By participating in telemedicine, you will be billed for the services provided and agree to allow Stormont Vail Health to charge your insurance for the treatments provided electronically. Just as with "in-person" services, you agree to the following:

- I hereby assign receipt of payment for medical services to Stormont Vail Health and any affiliate or practice of Stormont Vail Health, payment to be made directly to such provider.
- I understand that a \$10.00 processing fee will be charged when a co-pay is requested or prompted, and not paid at the time of service.
- I understand that there is no guarantee of payment from any insurance company or other payer. I acknowledge full financial responsibility for, and agree to pay, all charges of the hospital and of the physicians rendering services not otherwise paid by my health insurance. Remaining charges are due and payable upon receipt of the bill.
- I understand the hospital may request and use data from third parties such as credit reporting agencies in order to verify demographic data or evaluate financial options. I agree to pay costs of collection incurred by Stormont Vail Health, including, but not limited to, court costs, filing fees, interest and attorney fees. I acknowledge and understand that any refund that I may be owed will first be applied to any outstanding balance, and the remainder will be forwarded to the address on file.
- I consent to be contacted by regular mail, by e-mail, text message or by telephone (including my cell phone number) regarding any matter related to my services and accounts by Stormont Vail Health, or its approved agents or contractors. I understand this may include use of auto-dialers, pre-recorded messages, or both.
- I understand at times the level of care or medical necessity for services determined appropriate by my physician may differ from the opinion of my insurance company and it may deny payment in whole or in part. I authorize Stormont Vail Health to act on my behalf to file a grievance or appeal of such denial by my insurance company in accordance with applicable law and to also notify Stormont Vail Health directly of the determination of such grievances or appeals.

By participating in telemedicine services, I acknowledge that I have read and understood the information provided above. I have had or will have the opportunity to discuss telemedicine services with my provider or employees of Stormont Vail Health, to obtain answers to any questions I may have regarding telemedicine services.

I understand that in lieu of a physical or electronic signature to this Agreement, my continued participation with telemedicine services serves as my consent, which may also be affirmed verbally and may be documented in my medical record. I agree to these conditions, and authorize Stormont Vail Health to bill my insurance for any future telemedicine treatment I receive.

Signature of patient/parent/guardian/conservator

If signed by other than patient indicate relationship

Date