Doc Bee Well: Universal Telehealth Informed Consent

Doc Bee Well is a Washington State physician-owned medical practice providing telehealth services to patients located in states where the physician is licensed.

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1. Nature of Telehealth Services

Telehealth involves the use of electronic communications technology to enable healthcare delivery when the patient and provider are in different locations.

Telehealth may include:

- **Real-time video visits**
- **Audio-only visits**
- **Secure messaging**
- **Email or SMS communications**
- **Electronic prescribing**

You understand that telehealth may differ from in-person care and may have limitations in physical examination capability.

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2. Fees and Payment

- **All fees will be disclosed prior to service.**
- **Telehealth visits are subject to Doc Bee Well's published fee schedule.**
- **Doc Bee Well does not bill commercial insurance. Medicare billing policies will be disclosed to patients at the time of enrollment and may vary based on applicable federal requirements.**
- **You are responsible for:**
    - **Membership fees**
    - **Visit fees**
    - **Laboratory or diagnostic testing costs**
    - **Prescription costs**
    - **Third-party service charges**

Failure to complete payment may result in suspension of services.

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3. Privacy, Security, and Technical Risks

Doc Bee Well utilizes HIPAA-compliant electronic systems to protect your protected health information (PHI).

However, you acknowledge that:

- **Electronic transmission of data carries inherent risks.**
- **Technical failures may interrupt your visit.**
- **Unauthorized access, while unlikely, is possible.**
- **You are responsible for participating from a private and secure location.**

If technical disruption occurs, the provider may:

- **Attempt to reconnect**
- **Convert to phone**
- **Reschedule**
- **Recommend in-person care**

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4. Emergency Limitations: Telehealth services are not emergency services.

If you experience:

- **Chest pain**
- **Difficulty breathing**
- **Stroke symptoms**
- **Suicidal thoughts**
- **Any life-threatening condition**

You must call 911 or go to the nearest emergency department.

Doc Bee Well does not monitor messages continuously and is not responsible for emergency response.

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5. Website Owner / Operator Disclosure

Telehealth services are provided by:

Doc Bee Well, PLLC
1201 Pacific Ave, Suite 646
Tacoma, WA 98402
Phone: 253-777-3919
Email: admin@docbeewell.com

All services are delivered by a licensed physician in states where licensure is active.

No prescription drugs are sold or dispensed directly through the website.

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6. Patient Choice of Pharmacy and Provider

You have the right to:

- **Choose your pharmacy**
- **Request prescriptions be sent to a pharmacy of your choice**
- **Decline telehealth and request in-person care (when available)**
- **Seek a second opinion**

Doc Bee Well does not require the use of any specific pharmacy.

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7. Voluntary Consent

You may withdraw consent for telehealth at any time.

By signing below, you acknowledge:

- **You understand telehealth risks and limitations**
- **You consent to telehealth services**
- **You understand payment obligations**

By Agreeing to receive Telehealth Services from Doc Bee Well via phone, video, or electronic communications, I acknowledge that:

- I understand the information in this document including the potential risks to using electronic communications for a health care visit.
- I want a telehealth visit and may receive protected health information via email or SMS text messaging.
- I understand that the Practice has made reasonable and appropriate efforts to eliminate any confidentiality risks associated with Telehealth Services. I am also responsible for reducing any risks to my privacy or confidentiality resulting from the location or circumstances of my participation in Telehealth Services (e.g., joining the telehealth encounter from a quiet space, ensuring others do not overhear my conversation or see my computer or mobile device screen). I also understand that all existing confidentiality protections under federal and state law apply to my information disclosed during Telehealth Services.
- I understand that there are risks and consequences associated with telemedicine including, but not limited to the possibility, despite reasonable efforts on the part of my medical provider, that the transmission of my medical information could be disrupted or distorted by technical failures.
- I understand and acknowledge that Telehealth Services are not intended to be, and do not act as, emergency services. If I am experiencing an emergency, I should not rely on Telehealth Services and instead should call 911 or go to an emergency department.
- I understand what it means to receive Telehealth Services and am legally authorized to acknowledge, agree, and consent to the use of Telehealth Services.

- I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
- I understand that I will need to download an application and/or software to use this platform. I also need to have a broadband Internet connection or a smart phone device with a good cellular connection at home or at the location deemed appropriate for services.
- I understand that I have a right to access my health information and copies of medical records in accordance with Washington state law.
- I am responsible for all charges (a) that I may incur from my mobile or internet service provider, as applicable, when receiving Telehealth Services.

I have read and understand the information provided above regarding telehealth, have discussed it with my health care provider, counsel and/or legal guardian, and I hereby give informed consent to the use of telehealth.

Signature of Patient (or guardian/conservator) _____

Doc Bee Well Financial and No-show Policy

Please review the "Member Services" Guide posted on Doc Bee Well website, which describes types of services provided. By acknowledging this document, you agree that you have had the opportunity to ask questions and receive answers about its content.

- I acknowledge and understand that the monthly membership fee is paid in consideration for the services outlined in the Member Services Guide. I understand that if my care requires services or supplies that are not included in my membership, the fees for these services or supplies will be discussed with me in advance, and I will be responsible for paying these fees in full at the time of service.
- I acknowledge and understand that this agreement does not provide comprehensive health insurance coverage nor is it a contract of insurance. It only provides primary care health care services as specifically described in the Member Services Guide. I recognize that I am encouraged to obtain conventional private individual, catastrophic, or comprehensive health insurance.
- I acknowledge and understand that the monthly fee paid to Doc Bee Well does not cover the cost of prescription drugs, hospitalization costs, major surgery, dialysis, imaging, rehabilitation services, or procedures requiring general anesthesia, or similar advanced procedures, services or supplies and that I am responsible for any charges incurred for those services performed outside of Doc Bee Well.
- I acknowledge and understand that Doc Bee Well will not bill an insurance carrier, Medicare, or Medicaid for any services provided.
- I acknowledge and understand that If I am enrolled in Medicare, applicable Medicare billing disclosures or agreements will be provided as required by federal law.
- I acknowledge and understand that, to become a member of Doc Bee Well, I must submit a membership fee. Enrollment will include authorization for automatic payment of my membership fee which can be paid monthly or every 3, 6 or 12 months.
- I acknowledge and understand that my monthly membership fee will be automatically transferred from my selected choice of payment on the same day each month. The first day of the month is considered to be the beginning of that month's services. In the event payment is not received, Doc Bee Well will notify me through my given contact information and may charge a $25 late fee for any missed payment.
- I acknowledge and understand that Doc Bee Well may add or discontinue services included in the fee or increase my fee schedule at any time and that I will be given at least thirty (30) days' notice of fee schedule changes.
- I acknowledge and understand that Doc Bee Well may cancel this Member Agreement for cause due to non-payment of fees or for unruly, threatening, or inappropriate behavior by providing me written notice. Doc Bee Well will not cancel this Member Agreement solely on the basis of health status.
- I acknowledge and understand that I am free to cancel this Member Agreement at any time by providing written notice to Doc Bee Well by email, text, or letter (admin@docbeewell.com; (253) 263-7065; 1201 Pacific Ave, Ste 646, Tacoma, WA 98402). Monthly fees will continue to accrue until the written cancellation is received. I understand that my membership will end the day of my notice, there will be no refund for that month's membership if my notice falls on or after my selected date of payment.
- I acknowledge and understand that delinquent payment may result in termination of membership as well as report to collections

To keep overhead costs and membership fees down, the following financial and no-show policies apply to all members of the practice:

Method of payment
Individual members must keep a reliable method of payment on file, either a bank account or credit/debit card. It is the member's responsibility to keep this payment method current. Our billing system will send out automatic notifications if a payment does not go through, and patients are expected to respond to those notifications and correct the payment

Late and Non-Payment
If fees are not paid within 30 days of the due date, members will be notified of the delinquency and are at risk of suspension if not paid in full by 60 days and termination if not paid in full by 90 days. If terminated, members may not be eligible for reinstatement in the practice, and the practice reserves the right to reinstate at its discretion.

Financial Hardship
If you are unable to pay your fees on time, please contact the office at least 2 business days prior to your scheduled payment date to make arrangements. Members who are experiencing financial hardship are encouraged to contact the office to discuss; accommodation is made on a case-by-case basis.

No-shows and Late Cancellations
Members who do not show for their appointment or cancel an appointment with less than 24 hours' notice three times will be subject to scheduling restrictions and possible termination.

If cancelling your appointment 24 hours or less prior to an appointment, please text or call the office so that we can open the schedule to other patients.

I have read and understand the information provided above regarding Doc Bee Well Financial and No-Show Policies, have discussed it with my health care provider, counsel and/or legal guardian, and I hereby give informed consent to Doc Bee Well Financial and No-Show Policies.

Signature of patient (or guardian/conservator) _____

Doc Bee Well HIPAA Notice of Privacy Practices

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law.

It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills,

to support the operation of the physician's practice, and any other use required and authorized by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care for you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you.

We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization: as Required by Law, Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings: Law Enforcement, Coroners, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation, Inmates, Required Uses and Disclosures: under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction on dissemination of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively (i.e., electronically).

You may have the right to have your physician amend your protected health care information. If we deny your request for amendment, you have the right to file a statement of disagreement and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

State Mandated Exemptions:

- We are required by Washington State Law to disclose health information to the Department of Labor & Industries or a self-insured employer for workers' compensation or crime victims' claims.
- We can disclose health information to an employer about light duty work or restrictions without patient authorization.
- If a patient is covered by workers' compensation, HIPAA allows us to disclose a patient's personal health information to an employer regarding work-related illnesses or injuries without the patient's authorization (45 CFR § 164512(b)(v)(B)).
- We can disclose health information to an employer without patient authorization if that information is about a workplace injury or illness, workplace medical surveillance, or a return-to-work examination.
- Public health activities such as required reporting of immunizations, disease, injury, birth and death, or in connection with public health investigations.
- We are permitted and/or required by law to disclose your protected health information without your consent or authorization if we suspect child abuse or neglect; if we believe you to be a victim of abuse, neglect or domestic violence.
- To the Food and Drug Administration to report adverse events, product defects, or to participate in product recalls.
- If necessary to avert a serious and imminent threat to your, or someone else's, health or safety, or to permit law enforcement authorities to identify or apprehend an individual.
- To state or federal agencies and programs, where the law permits or requires it.
- To military authorities, in some situations, if you are armed forces personnel or a veteran.
- When authorized or required to do so in the course of lawsuits or administrative hearings.

Because these disclosures to the department or self-insurer are required by law, patients cannot object to or request that we restrict those disclosures (45 CFR, 164. 522(a)(1)(v)).

Complaints:

You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and became effective on January 1, 2024.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

I have read and understand the information provided above regarding HIPAA Notice of Privacy Practices, have discussed it with my health care provider, counsel and/or legal guardian, and I hereby give informed consent to Doc Bee Well HIPAA Notice of Privacy Practices.

Signature of patient (or guardian/conservator) _____

Doc Bee Well
Patient Rights and Responsibilities

- I agree to disclose all information relating to my health condition and to actively collaborate with my health care provider to understand my treatment options and develop the best course of action.

- I understand that my enrollment in Doc Bee Well is a commitment to my ongoing health and wellness. I agree to commit to those plans for my medical care which have been agreed upon by me and my provider.

- I understand that I will be forthright regarding my prescription medication and my use of them.

- I understand that Doc Bee Well does not contract with Labor and Industries (worker's comp) nor do its providers complete evaluations for a commercial driver's license, nor manage injuries related to motor vehicle accidents or injury.

- I understand that Doc Bee Well does not provide management of chronic/long term narcotic or benzodiazepine prescription use.

- I understand that it is my responsibility to inform Doc Bee Well of any changes to my credit/debit card or bank account information used by Doc Bee Well.
- I understand that it is my responsibility to ensure that Doc Bee Well has correct contact information (e.g. mailing address, phone) for my account.

- I agree to arrive on time for my appointment. If I do not arrive on time, my provider may not be able to spend as much time with me as I may need. In addition, I agree to call Doc Bee Well at least 24 hours before an appointment if I need to cancel, so that other patients can use my visit time. I understand that same-day cancellations are subject to a $15 cancellation fee. These fees do not apply to patients in Honeybee or Worker Bee membership.

- I understand that I have the right to receive accurate and easily understood information about Doc Bee Well health care services, health care professionals, and health care facilities.

- I understand that I have the right to speak confidently with my Doc Bee Well provider and to have my health care information protected. I understand that Doc Bee Well will not disclose my information without my authorization or without a legal obligation to do so. I also understand that I have the right to review and receive a copy of my personal medical record and may request that my health care provider amend my record if I feel it is inaccurate or incomplete by contacting my Doc Bee Well provider.

- I understand that the monthly fee is intended to cover Doc Bee Well provider's availability to provide services as well as the individual services provided, and that the monthly fee is due each month under the Member Agreement, even if I do not communicate with Doc Bee Well providers or see them during a particular month.

- I understand that I am responsible for all bills associated with services provided outside the direct agreement for primary care services, whether provided by Doc Bee Well or another organization or individual.

- In the event I wish to cancel my membership, I understand that I must notify Doc Bee Well in writing of my intent to cancel. Notice by email or text is sufficient. If my account is overdue, I am responsible for resolving the outstanding balance within 90 days or be subject to collections reporting.
- I understand that if I am dissatisfied for any reason, I may contact the Clinic's Administrator to address any complaints at the address provided below. I agree to first bring issues to Doc Bee Well's attention.

Doc Bee Well Administrator

1201 Pacific Ave, Suite 646,
Tacoma, WA 98402
Email: admin@docbeewell.com

Washington State Department of Health Systems Quality Assurance Complaint Intake

P.O. Box 47857
Olympia, WA 98504-7857
Phone: 360-236-4700
1-800-633-6828 (toll-free)

Fax: 360-236-2626
Email: HSQAComplaintIntake@doh.wa.gov

Washington Medical Commission

WMC Complaint Intake
P.O. Box 47866
Olympia, WA 98504
Email: to Medical.complaints@wmc.wa.gov

If located in Utah:
1. The provider is licensed in Utah at the time services are rendered.
2. You are entitled to:
    - Provider identity disclosure
    - Provider license number upon request
3. You may file complaints with the Utah Division of Professional Licensing
4. Telehealth services are subject to Utah's standard of care.
5. The provider will disclose their name, licensure status, and contact information at the time of service. If telehealth services are not clinically appropriate, the provider may recommend in-person evaluation or referral.
6. Controlled substances will be prescribed only in compliance with Utah law.
7. You have the right to choose your pharmacy.
8. You may request in-person follow-up care if medically appropriate.

If located in Idaho:
1. Provider must hold active Idaho license.
2. Complaints may be filed with the Idaho Board of Medicine
3. Prescribing is subject to Idaho law.
4. The provider will verify the patient's identity and physical location at the time of each telehealth encounter
5. You may choose your pharmacy freely.
6. Telehealth does not replace emergency care.

If located in Ohio:
1. Provider must be licensed in Ohio.
2. The provider will verify the patient's identity and physical location at the time of each telehealth encounter
3. Complaints may be filed with the State Medical Board of Ohio
4. Ohio telehealth prescribing laws apply.
5. You retain pharmacy choice.
6. Emergency services are not provided via telehealth.

If located in Colorado:
1. Provider must hold active Colorado license.
2. Complaints may be filed with the Colorado Medical Board
3. Colorado telehealth and prescribing laws apply.
4. The provider will verify the patient's identity and physical location at the time of each telehealth encounter
5. You retain full pharmacy choice.

If located in Missouri:
1. Provider must hold active Missouri license.
2. Complaints may be filed with the Missouri Board of Registration for the Healing Arts
3. Missouri telehealth statutes apply.
4. The provider will verify the patient's identity and physical location at the time of each telehealth encounter
5. You may select any pharmacy.
6. Telehealth does not replace emergency services.

If located in Kansas:
1. Provider must hold active Kansas license prior to treatment.
2. Complaints may be filed with the Kansas State Board of Healing Arts
3. Kansas telemedicine standards apply.
4. The provider will verify the patient's identity and physical location at the time of each telehealth encounter
5. Pharmacy choice is unrestricted.
6. Telehealth is not emergency care.

If located in Florida:

1. Provider must hold active Florida license.
2. Complaints may be filed with the Florida Board of Medicine
3. Florida telehealth statute (F.S. 456.47) governs services.
4. The provider will verify patient identity and physical location at the time of each telehealth encounter as required by Florida law.
5. You may choose your pharmacy freely.
6. Telehealth services are subject to Florida standards of care.
7. Emergency services are not provided via telehealth.

I have read and understand the information provided above regarding Patient Rights and Responsibilities, have discussed it with my health care provider, counsel and/or legal guardian, and I hereby give informed consent to Doc Bee Well Patient Rights and Responsibilities.

Signature of patient (or guardian/conservator) _____

Printed name _____

Date_____