



# Doc Bee Well: Consent for Telehealth Visits

## What is telehealth?

Telehealth is a way to visit healthcare providers, such as your doctor or nurse practitioner using electronic communications and video conferencing. You can talk to your provider from any place, including your home. You don't go to a clinic or hospital. This can include audio-only visits or video visits. Telehealth can also include email or text messages to your healthcare provider. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of client identification and imaging data and will include measures to safeguard the data and to ensure its integrity from any unauthorized use.

## How do I use telehealth?

- You talk to your provider by phone, computer, or tablet.
- Doc Bee Well utilizes an integrated electronic health record that has an embedded HIPPA compliant video service for telehealth appointments. We also utilize a HIPPA secured phone system and email platform.

## Benefits of using telehealth

- Access to the same healthcare standards as seeing the doctor in person.
- You don't have to go to a clinic or hospital to see your provider and visits can be completed where you feel most comfortable.
- You won't risk getting sick from other people.
- Often patients do not need to take time off from work to visit the doctor.
- Your doctor can often obtain more information about you and where / how you live and your lifestyle, thereby providing personalized care.
- You can obtain the expertise of a distant specialist.

## Risks to using telehealth

*There are potential risks associated with the use of telehealth. These risks include, but may not be limited to:*

- You and your provider won't be in the same room, so it may feel different than an office visit.
- Your provider may make a mistake because they cannot examine you as closely as at an office visit. (We don't know if mistakes are more common with telehealth visits.)
- Your provider may decide you still need an office visit.
- Technical problems may interrupt or stop your visit before you are done.

## Will my telehealth visit be private?

- We will not record visits with your provider unless both Doc Bee Well and patient consent to the recording. Under RCW 9.73.030, It is a violation of Washington privacy laws to tape someone without their knowledge.
- If people are close to you, they may hear something you did not want them to know. You should be in a private place, so other people cannot hear you.
- Your provider will tell you if someone else from their office can hear or see you.
- We use telehealth technology that is designed to protect your privacy.
- If you use the Internet for telehealth, use a network that is private and secure.
- In rare cases, security protocols could fail, causing a breach of privacy of personal health information.

## What if I want an office visit, not a telehealth visit?

Our unique business model is designed to have almost all visits by telehealth. Doc Bee Well does have a physical office that they can see patients in person when appropriate and also has the ability to perform home visits if you are in the service area. You can stop using telehealth any time, even during a telehealth visit. If Doc Bee Well makes a professional judgement that telehealth services aren't suitable, Doc Bee Well has the right to decline care via telehealth and require in person visits.

**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, I will receive a copy of the “Medicare Opt-Out Agreement” for review and signature before my first appointment.
- 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, HIPPA 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 HIPPA 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 HIPPA 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 with regard to 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 accident 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 the 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 in confidence 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. I understand that I may address any unresolved complaints to the attention of the Office of the Insurance Commissioner for the State of Washington by calling the Consumer Advocacy department at: (800) 562-6900 or by e-mail at [cad@oic.wa.gov](mailto:cad@oic.wa.gov).

#### **Doc Bee Well Administrator**

1201 Pacific Ave, Suite 646,  
Tacoma, WA 98402  
Email: [admin@docbeewell.com](mailto:admin@docbeewell.com)

**Office of the Insurance Commissioner for the State of Washington**



(800) 562-6900

Email: [cad@oic.wa.gov](mailto:cad@oic.wa.gov)

**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](mailto:HSQAComplaintIntake@doh.wa.gov)

**Washington Medical Commission**

WMC Complaint Intake

P.O. Box 47866

Olympia, WA 98504

Email: [to.Medical.complaints@wmc.wa.gov](mailto:to.Medical.complaints@wmc.wa.gov)

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 \_\_\_\_\_

