# Preferred Health Solutions (PHS)

## Informed Consent to Telemedicine Services and PHS Policies

**This form describes PHS's Telemedicine treatment and payment policies and includes:**

- **Your consent to receive medical treatment from** PHS **(and your other rights and responsibilities);**
- **Your agreement to receive services using Telemedicine technology; and**
- **Your agreement to pay in full any charges that are your responsibility.**

1. I agree to receive Telemedicine services. Telemedicine involves the delivery of health care services, including assessment, treatment, diagnosis, and education, using interactive audio, video, and data communications. During my visit, my PHS provider and I will be able to see and speak with each other from remote locations.
2. I understand and agree that:
   - I will not be in the same location or room as my medical provider.
   - My PHS provider is licensed in the state in which I am receiving services. I will report my location accurately during registration.
   - Potential benefits of Telemedicine (which are not guaranteed or assured) include: (i) access to medical care if I am unable to travel to my PHS provider's office; (ii) more efficient medical evaluation and management; and (iii) during the COVID-19 pandemic, reduced exposure to patients, medical staff and other individuals at a physical location.
   - Potential risks of Telemedicine include: (i) limited or no availability of diagnostic laboratory, x-ray, EKG, and other testing, and some prescriptions, to assist my medical provider in diagnosis and treatment; (ii) my provider's inability to conduct a hands-on physical examination of me and my condition; and (iii) delays in evaluation and treatment due to technical difficulties or interruptions, distortion of diagnostic images or specimens resulting from electronic transmission issues, unauthorized access to my information, or loss of information due to technical failures. I will not hold PHS responsible for lost information due to technological failures.
   - I further understand that my PHS Provider's advice, recommendations, and or decisions may be based on factors not within his/her control, including incomplete or inaccurate data provided by me. I understand that my PHS provider relies on information provided by me before and during our Telemedicine encounter and that I must provide information about my medical history, condition(s), and current or previous medical care that is complete and accurate to the best of my ability.
   - I may discuss these risks and benefits with my PHS provider and will be given an opportunity to ask questions about Telemedicine services. I have the right to withdraw this consent to Telemedicine services or end the Telemedicine session at any time without affecting my right to present or future treatment by PHS.
   - I understand that the level of care provided by my PHS provider is to be the same level of care that is available to me through an in-person medical visit. However, if my provider believes I would be better served by face-to-face services or another form of care, I will be

referred to the PHS doctor, hospital emergency department or other appropriate health care provider.
    - I have the right to receive face-to-face medical services at any time by requesting an office visit.
    - In case of an emergency, I will dial 911 or go directly to the nearest hospital emergency room.
3. I consent to, understand and agree that:
    - I have the right to discuss the risks and benefits of all procedures and courses of treatment proposed by my health care provider(s), together with any available alternatives.
    - PHS will provide care consistent with the prevailing standards of medical practice but makes no assurances or guarantees as to the results of treatment.
    - Before prescribing any controlled substance to me, PHS may review information from the Prescription Drug Monitoring Program in my state of residence regarding my prior receipt of controlled substances.
    - My PHS provider will not prescribe opioids to me during a Telemedicine visit.
    - I have the right to review and receive copies of my medical records, including all information obtained during a Telemedicine interaction, subject to PHS's standard policies regarding request and receipt of medical records and applicable law.
    - The laws of the state in which I am located will apply to my receipt of Telemedicine services.

## PHS Notice of Privacy Practices ("Privacy Notice")

PHS will protect the privacy of my health information and will not use or disclose it except as permitted by law. PHS's privacy policies are more fully described in the Privacy Notice, which is available for review and download here: https://preferredhealthsolutions.org/patient-resources. By signing this Consent, I acknowledge receipt of the Privacy Notice and consent to PHS's use and disclosure of my health information in accordance with its terms. I understand that all existing confidentiality protections that apply to in-person treatment apply to Telemedicine services.

# Payment Policy

I acknowledge, understand and agree that:

1. Each Telemedicine visit is $60 and it is my responsibility to make sure that my bill is paid for PHS's services.
2. I will pay at time of service any required co-payments as well as charges for services rendered.
3. I will be billed for all unpaid balances deemed by PHS and it is my responsibility to agree and pay such amounts in full.
4. Payment may be made online by visiting: https://preferredhealthsolutions.org/billing/payment

☐ "I agree to Terms of Use" on the PHS Telemedicine, I understand and agree that I by checking this box, and signing below, I am signing this Consent and that (i) I have reviewed, understand and accept the risks and benefits of Telemedicine services as described above and wish to receive such

services, and (ii) I agree to the remaining terms of this Consent, including the terms of the PHS Privacy Notice described above.

If I am signing on behalf of a minor, incapacitated or otherwise legally dependent patient, I certify that I am a person with legal authority to act on behalf of the patient, including the authority to consent to medical services, and I accept financial responsibility for services rendered.

I understand that I may access and print a copy of this Consent here.
https://preferredhealthsolutions.org/patient-resources

Patient Name:_____ Relationship to Patient : _____

Signature:_____ Date:_____