Tele-Health Policy and Procedures

Patient agrees to virtual e-visit service terms, privacy policy, and charge for receiving a virtual visit from a physician or other qualified health professional.

NEVER REQUEST AN ELECTRONIC VISIT FOR AN URGENT MEDICAL PROBLEM, CALL 911 INSTEAD.

An electronic or e-visit is an alternative designed to efficiently respond to routine, non-complex medical problems. (Examples might include: a cold or sinus infection, a mild stomach virus, follow-up of a stable chronic condition). An e-visit is not designed for complex or non-routine medical care especially problems that might require the relating of extensive history information or a thorough physical exam. E-visits are only offered to established patients and you agree that during the visit you are representing yourself and not another person. Provider reserves the right to decline request for an e-visit at their discretion.

E-visits can be considered a non-covered service. If your insurance company determines the visit to be a non- covered service, the patient is responsible for our typical e-visit charges. Our standard e-visit charge is $75 although additional services or screenings could cause that charge to change.

Though a payment may not be requested today, virtual e-visits will be billed to the patient's health insurance carrier. Jones Family Practice Clinic will submit claim charges to the patient's insurance carrier for charges associated with the virtual e-visit. Once the patient's insurance carrier has processed the claim if a balance remains under patient responsibility, Jones Family Practice Clinic will send out a statement to the patient for the remaining balance. Patient agrees to remit payment for balances/ charges not covered by their health insurance carrier.

Requests for e-visits must be confirmed and scheduled by our office prior to the e-visit. Prior to the visit you may be asked to complete certain medical questionnaires. Sometimes, after reviewing your information, or during the e-visit it may be determined that your problem is too complex for an e-visit session. In that case our office will schedule you for a traditional office visit and your e-visit fee will be applied to the patient balance related to your office visit or refunded per our practice's billing policy.

The physician or provider appropriately documents the virtual e-visit, including all pertinent communication- related to the encounter, in the patient's medical/health record. The physician or other qualified health professional has a defined period of time within which responses to a virtual e-visit request are completed. During the virtual e-visit, the physician or provider may make recommendations, provide medical advice and/or prescribe, refill or recommend medications. The physician or provider may suggest the patient receive additional care, examination, testing and/or treatment at a medical facility in-

person. If necessary, the physician or provider may also suggest that the patient receive care in an emergency room.

Communication during an e-visit may be exchanged via teleconference. Insurances are now requiring video plus audio for all telehealth visits. These methods are by their very nature not as secure as a face-to-face encounter. By requesting an e-visit you acknowledge that personal health information will be communicated in a manner that is subject to hacking and other malicious behavior. Terms of this agreement include the main method of electronic communication that occurs over a HIPAA-compliant online connection (healow Telehealth Solutions). A virtual e-visit may include the total interchange of online inquiries and other communications associated with this single patient encounter, subject to determination of the physician or other qualified healthcare provider.

As with any medical service, decision, or treatment, there are risks; and, an e-visit is no different. Because this visit is electronic and not in person, you acknowledge that the risk may be greater than a traditional office visit, and by requesting the visit you agree to accept the outcome-even if it is undesirable. In addition, you agree to abide by our office's routine policies including any policy related to litigation.

_____ _____

Patient or Parent/Guardian Signature Date *(update yearly)*

_____

Provider or Authorized Representative Signature

NOTICE OF HEALTH INFORMATION 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.

Protected health information is stored electronically and is subject to electronic disclosure.
If you have any questions about this notice, please contact the ***Jones Family Practice Clinic*** at 918-912.5372.

This Notice Describes Our Practices and Those of:

- Any medical staff member and any health care professional who participates in your care; à Any volunteer we allow to help you while you are here; and à All employees of any hospital, clinic, laboratory, or other facility affiliated with ***Jones Family Practice Clinic***.

All of these people follow the terms of this notice. They may also share health information that identifies you (also known as "protected health information") with each other for treatment, payment or health care operations as described in this notice.

Our Pledge Regarding Health Information:
We understand that health information about you and your health is personal. We are committed to protecting health information about you. This notice will tell you about the ways that we may use and disclose health information about you. This notice also describes your rights and certain obligations we have regarding the use and disclosure of protected health information. We are required to comply with any state laws that offer a patient/plan member additional privacy protections.

We Are Required by Law To:

Maintain the privacy of health information that identifies you;

- Give you and other individuals this notice of our legal duties and privacy practices with respect to protected health information;
- Follow the terms of the notice that is currently in effect; and Notify affected individuals in the event of a breach involving unsecured protected health information.

How We May Use and Disclose Your Health Information:

- **For Treatment**. We may use and disclose your health information to provide you with medical treatment or services. For example, a health care provider, such as a physician, nurse, or other person providing health services will access your health information to understand your medical condition and history. Health care providers will also record actions taken by them in the course of your treatment and note how you respond to the actions. This information is necessary for health care providers to determine what treatment you should receive and to coordinate your care.
- **For Payment**. We may use and disclose your health information for purposes of receiving payment for treatment and services that you receive. For example, we may disclose your information to health plans or other payors to determine whether you are enrolled with the payor or eligible for health benefits or to submit claims for payment. The information on our bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment. We may provide health information to entities that help us submit bills and collect amounts owed, such as a collection agency.
- **For Health Care Operations**. We may use and disclose your health information for operational purposes. For example, your health information may be used by, and disclosed to, members of the medical staff, risk or quality improvement personnel, and others to evaluate the performance of our staff, to assess the quality of care and outcomes in your case and similar cases, to learn how to improve our facilities and services, for training, to arrange for legal or risk management services and to determine how to continually improve the quality and effectiveness of the health care we provide.
- **Health Information Exchange**. We may participate in one or more health information exchanges or other health information registries and may use and disclose your health information through these exchanges for certain purposes described in this notice. For example, we may disclose your health information to or obtain your health information from other participants in a health information exchange that have treated you in order to coordinate your care. We may use a health information exchange to obtain information for payment for the care you receive. We may also disclose or obtain your health information through a health information exchange for quality assessment or improving health and reducing health care costs. We may disclose your health information to an electronic health information registry to report certain diseases or for other public health purposes.
- **Others Involved In Your Care**. We may disclose relevant health information to a family member, friend, or anyone else you designate in order for that person to be involved in your care or payment related to your care. We may also disclose health information to those assisting in disaster relief efforts so that others can be notified about your condition, status and location.
- **Fundraising**. We do not use or disclose your information for fundraising.
- **Required By Law**. We may use and disclose information about you as required by law. For example, we are required to disclose information about you to the U.S. Department of Health and Human Services if it requests such information to determine that we are complying with federal privacy law.
- **Reporting Abuse, Neglect or Domestic Violence**. We may disclose health information to an appropriate government authority, including a protective services agency, if we believe an

individual is the victim of abuse, neglect or domestic violence. We will inform the individual that we have made such a report, unless we believe that doing so would place the individual at serious risk of harm. We will make such reports only as required or authorized by law, or if the individual agrees.

- **Public Health**. Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities (*e.g.*, state health department, Center for Disease Control, *etc.*) to prevent or control disease, injury, or disability, or for other public health activities.
- **Law Enforcement Purposes.** Subject to certain restrictions, we may disclose information needed or requested by law enforcement officials.
- **Judicial and Administrative Proceedings.** We may disclose information in response to an appropriate subpoena, discovery request or court order.
- **Health Oversight Activities**. We may disclose your health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections to monitor the health care system.
- **Decedents**. Health information may be disclosed to funeral directors, medical examiners or coroners to enable them to carry out their lawful duties.
- **Health and Safety**. Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law. • **Workers' Compensation**. Your health information may be used or disclosed in order to comply with laws and regulations related to Workers' Compensation.
- **Business Associates.** We may disclose your health information to business associates (individuals or entities that perform functions on our behalf) provided they agree to safeguard the information.
- **Other Uses and Disclosures**. We may contact you to provide appointment reminders or for billing or collections and may leave messages on your answering machine, voice mail or through other methods. Except for uses and disclosures described above, we will only use and disclose your health information with your written authorization. Subject to compliance with limited exceptions, we will not use or disclose psychotherapy notes, use or disclose your health information for marketing purposes or sell your health information, unless you have signed an authorization. You may revoke an authorization by notifying us in writing, except to the extent we have taken action in reliance on the authorization.

Your Health Information Rights:

You have the right to:

- Obtain a paper copy of this notice of information practices upon request, even if you have previously agreed to receive this notice electronically.
- Inspect and obtain a copy of your health information that we maintain or direct us to send a copy of your health information to another person designated by you in writing. In most cases we will provide this access to you, or the person you designate, within 30 days of your request.

- Request an amendment to your health information if you think it is incorrect or incomplete. We may say "no" to your request, but we will tell you why within 60 days of receiving your request.
- Request a confidential communication of your health information by alternative means or at alternative locations. Please be advised that this request for alternative means or locations of communications applies only to this provider or location.
- Receive an accounting (a list) of the disclosures we have made of your health information for the six years prior to your request, except for certain disclosures that we are not required to include (such as disclosures that you have authorized us to make). We will also include in the list the reason for the disclosure and the recipient. We will provide one accounting per year at no charge, but if you ask for additional accountings within the same 12-month period, we may charge a reasonable, cost-based fee.
- Request a restriction on certain uses and disclosures of your information. We are not required to agree to a requested restriction, except for requests to limit disclosures to your health plan for purposes of payment or health care operations when you have paid for the item or service covered by the request out-of-pocket and in full and when the uses or disclosures are not required by law.

If you have given another individual a medical power of attorney, or if another individual is appointed as your legal guardian or is authorized by law to act on your behalf, that individual may exercise any of the rights listed above for you. We will confirm this individual has the authority to act on your behalf before we take any action.

To exercise any of these rights, please contact our Privacy Officer at the address at the end of this notice.

Changes to This Notice:

We reserve the right to change the terms of this notice and make the new terms effective for all protected health information kept by ***Jones Family Practice Clinic***. We will post a copy of the current notice in our facility. You may also get a current copy by contacting our Office Manager at the address at end of this notice. The effective date of the notice is in the top right-hand corner of each page.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with ***Jones Family Practice Clinic*** or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with ***Jones Family Practice Clinic***, submit your written complaint to our Office Manager at the address at end of this notice. You will not be penalized for filing a complaint.

Contact Information for Questions or To File a Complaint:

If you have any questions about this notice, want to exercise one of your rights that are described in this notice, or want to file a complaint, please contact the ***Jones Family Practice Clinic*** at 918-912.5372.

Jones Family Practice Clinic, 1118 W Broadway St, Muskogee, OK 74401, ph 918-912.5372

I have read and understand the HIPAA policy and agree to abide by its guidelines:

_____ _____

Signature of Patient or Responsible Party **Date**

Jones
Family Practice Clinic

1. RISK OF USING E-MAIL

Transmitting patient results by e-mail has a number of risks that patients should consider before authorizing receipt of e-mail transmissions. These include but are not limited to the following risks:

a. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) recommends that e-mail that contains protected health information be encrypted. All transmissions from ***Jones Family Practice Clinic*** will be encrypted and will require the patient to establish an account with a password to view.
b. E-mail can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
c. E-mail senders can easily misaddress an email.
d. Back-up copies of e-mail may exist even after sender has deleted his copy.
e. Employers and on-line services have a right to inspect e-mail transmitted through their systems.
f. E-mail can be used to introduce viruses into computer systems.
g. E-mail can be intercepted, altered, forwarded, or used without authorization or detection.

2. CONDITIONS FOR USE OF E-MAIL

Jones Family Practice Clinic cannot guarantee the security and confidentiality of e-mail but will use reasonable means, including e-mail encryption, to maintain security and confidentiality. The facility and physicians are not liable for improper disclosure of confidential information that is not caused by practice or physician intentional misconduct. Patients must acknowledge and comply with the following:

a. All e-mails sent from the facility will be one way. Patients will not be allowed to respond since the e-mail address will not be monitored. The e-mails will be sent from donotreply@***JonesFPC***.com
b. Provide a valid e-mail address and inform the facility of any future address change.
c. Establish an account to open encrypted emails upon receipt of first encrypted e-mail.
d. Protect his/her password to the encrypted e-mail.

3. PATIENT ACKNOWLEDGE AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail from ***Jones Family Practice Clinic***, and I consent to the conditions outlined as well as any other instructions that the practice may impose to communicate with patient by e-mail. If I have questions, I may inquire with the manager.

Email address (please print): _____

Patient Name Printed: _____ **DOB** _____

Patient Signature: _____ **Date**_____

Patient Consent for Use & Disclosure of Protected Health Information for Treatment, Payment & Health Care Operations

I hereby give my consent for Robert Jones, APRN and Jones Family Practice Clinic to use and disclose my protected health information (PHI) to perform treatment, payment, and health care operations (TPO).

With this consent, the Practice may call, text or email me to my home/cell phone or other alternative location and leave a message by voice, email or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and anything pertaining to my clinical care, including laboratory test results.

With this consent, the Practice may mail to my home or other alternative location any items that assist the practice in performing TPO, such as appointment reminder cards, patient statements and anything pertaining to my clinical care as long as they are marked "Personal and Confidential."

By signing this form, I am consenting to allow the Practice to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the Practice has already made disclosures upon my prior consent. If I do not sign this consent, or later revoke it, the Practice may decline to provide treatment to me.

Signature: _____ Date: _____

Patient Name: _____