HMC
HIGHLAND MEDICAL CENTER
Caring for the health of the Highlands

Patient Name: _____ DOB: _____

Limitations on Confidential Nature of Communications

Communications between a licensed psychologist, psychiatrist, licensed clinical social worker, or licensed professional counselor and the patient are confidential and will not be released without the expressed authorization of the patient. However, certain communication may occur where confidentiality is limited. They are as follows:

- Should a provider believe the patient is a threat to others or themselves
- When records are ordered to be released by a Judge or Court
- When information involves child abuse or abuse of the elderly
- When information is given about the transmission of contagious or transmittable diseases
- Should the patient's account be turned over to an attorney/collection agency for non-payment
- When you are determined incapacitated by your health care provider information may be given to your guardian or medical power of attorney

I acknowledge that I understand and agree to the above payment policy and limitations of confidentiality.

_____ _____
Patient/Parent/ Responsible Party Date

_____ _____
Staff Date

Consent to Treat

I understand that as in all types of medical and psychological treatment, there are certain risks. This includes the general risk that there may be emotional pain, stress, and/or life changes associated with mental health treatment helps many individuals, it is not always completely effective. I hereby give written consent for mental health treatment. My clinician will inform me of other specific treatment risks that may be involved in my case, and/or I will ask any questions I may have about specific treatment risks.

_____ _____
Patient/Parent/ Responsible Party Date

HMC
HIGHLAND MEDICAL CENTER
Caring for the health of the Highlands

CONSENT FOR TELEHEALTH SERVICES

PATIENT NAME: _____ **DATE OF BIRTH:** _____

Telemedicine involves the use of electronic communications to enable health care providers at to share individual patient medical information for the purpose of improving patient care. Providers may include Primary Care practitioners, Dental practitioners, and Behavioral Health practitioners. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Possible Risks

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors.

By agreeing to this service, I understand the following:

1. I understand that my health care provider wishes me to engage in a telemedicine consultation.
2. My health care provider has explained to me how the video conferencing technology will be used to affect such a consultation.
3. I understand that telemedicine visits will not be the same as a direct patient/health care provider visits due to the fact that I will not be in the same room as my health care provider.

HMC
HIGHLAND MEDICAL CENTER
Caring for the health of the Highlands

4. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
5. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my health care provider and consulting health care provider in order to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following:
    i. Omit specific details of my medical history/physical examination that are personally sensitive to me;
    ii. Ask non-medical personnel to leave the telemedicine examination room: and or
    iii. Terminate the consultation at any time.
6. I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a telemedicine consultation. I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting health care provider.
7. I understand that billing will occur from Highland Medical Center.
8. I have had a direct conversation with my Provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

Patient Consent to the Use of Telemedicine

- I have read or had this form read and/or had this form explained to me
- I fully understand its contents including the risks and benefits of the procedure(s).
- I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Patient/ Parent/ Guardian Signature _____

Witness if Verbal Consent _____

Date _____

Understanding Health Information Privacy

The HIPAA Privacy Rule provides federal protections for individually identifiable health information held by covered entities and their business associates and gives patients an array of rights with respect to that information. At the same time, the Privacy Rule is balanced so that it permits the disclosure of health information needed for patient care and other important purposes. HMC can receive and share health information with other health professionals and hospitals who are treating you.

The Security Rule specifies a series of administrative, physical, and technical safeguards for covered entities and their business associates to use to assure the confidentiality, integrity, and availability of electronic protected health information.

By completing below, I am acknowledging that I have read the Highland Medical Center's Privacy Notice, have been offered a copy, and had an opportunity to ask question.

Printed Name of Patient: _____

Date of Birth of Patient: _____

Printed Name of Guardian, if appropriate: _____

Signature of Patient or Guardian: _____Date: _____

RELEASE OF INFORMATION

Often it is difficult to reach a patient to convey physician orders or test results. In this event, with your signed authorization, we would release such information to a person you designate. Please complete the section below.

I authorize Highland Medical Center, Inc. to release any information required in the course of my examination or treatment to the following designated person(s):

PLEASE CIRCLE WHICH ONE IS YOUR EMERGENCY CONTACT

Name: _____ Relationship & Phone #: _____

Name: _____ Relationship & Phone #: _____

Name: _____ Relationship & Phone #: _____

ADVANCE DIRECTIVE (Living Will/ Medical Power of Attorney)

An Advance Directive is a legal document that states your wishes regarding medical treatment in the event that you are unable to communicate these decisions. *It is very important that all of your healthcare providers have a current copy of these documents.*

____ I HAVE completed an Advance Directive.
Copy provided to HMC? Yes / No

____ I HAVE NOT completed an Advance Directive.
I would like more information. Yes / No