Oasis Informed Consent To Treatment

This Informed Consent to Treatment contains important information about the health care services, including telehealth services, provided by (your practice name). This form also includes a description of the nature of the services and the anticipated benefits and potential risks of, and alternatives to, such services. Please read this document carefully. Checking the box below signifies your informed consent to receive health care services, including telehealth services, from (your practice name).

You have the right to be informed about your condition(s) and the recommended treatment for such conditions so that you may decide whether to undergo any suggested treatment after being informed of the anticipated benefits and potential risks of, and alternatives to, such treatment. At this point in your care, no specific treatment plan has been recommended.

By accepting this Consent, you give your informed consent to receive medical treatment from (your practice name) and to comply with the conditions described herein. If additional, specific treatment is recommended that is not addressed in this Consent, you will be asked to read and sign additional consent forms prior to receiving such treatment. This consent will remain fully effective until it is revoked in writing.

You have the right to discontinue services and/or decline any and all treatments at any time, even if against medical advice. You have the right to discuss your treatment plan with your Provider, including any benefits, potential risks, and alternatives to your treatment. If you have any questions or concerns regarding any treatment recommended by your Provider, we encourage you to talk to your Provider.

DESCRIPTION OF TELEHEALTH SERVICES

Telehealth involves the use of secure electronic communications, information technology, or other mean to enable a health care provider and a patient at different locations to communicate and exchange individual patient health information via Electronic Transmissions for the purpose of rendering clinical care. This Informed Consent informs you, the patient (“patient”, “you”, or “your”), about the treatment methods, risks, and limitations of engaging in telehealth services.

Services Provided:

Telehealth services offered by (your practice name) may include a patient consultation, diagnosis, treatment recommendation, prescription, and/or a referral to in-person care, as determined clinically appropriate (the “Services”). Your Provider will be licensed in the state where you are located at the time of your consultation, or otherwise meet a professional licensure exception under applicable state law, and will establish a provider-patient relationship in accordance with the laws and rules in the applicable state.

Electronic Transmissions:

The types of electronic transmissions that may occur using the telehealth platform include, but are not limited to:

- Appointment scheduling;
- Completion, exchange, and review of medical intake forms and other clinically relevant information (for example: health records; images; output data from medical devices; sound and video files; diagnostic and/or lab test results) between you and your Provider via:
    - asynchronous communications;
    - two-way interactive audio in combination with store-and-forward communications; and/or
    - two-way interactive audio and video interaction;
- Treatment recommendations by your Provider based upon such review and exchange of clinical information;
- Delivery of a consultation report with a diagnosis, treatment and/or prescription recommendations, as deemed clinically relevant;

- Prescription refill reminders (if applicable); and/or
- Other electronic transmissions for the purpose of rendering clinical care to you.

Expected Benefits:

- Improved access to care by enabling you to remain in your preferred location while your Provider consults with you. Our telehealth services are available 24 hours a day, 7 days a week.
- Convenient access to follow-up care. If you need to receive non-emergent follow-up care related to your treatment, please contact your Provider by (preferred contact method)
- More efficient care evaluation and management. You can expect a response within 24 hours during the business day by a trained health coach for any administrative and/or care coordination issues. Your Provider will typically respond to any non-emergent messages within 7 business days during the week or during the next business days over weekends and holidays.

Service Limitations:

- The primary difference between telehealth and direct, in-person service delivery is the inability to have physical contact with the patient. Accordingly, some clinical needs may not be appropriate for a telehealth visit and your Provider will make that determination.
- **Our Providers do not address medical emergencies. If you believe you are experiencing a medical emergency, you should dial 911 and/or go to the nearest emergency room. Please do not attempt to contact your Provider. After receiving emergency healthcare treatment, you should visit your local primary care provider.**
- Our Providers offer services in addition to, and not a replacement for, those of your local primary care provider. Responsibility for your overall medical care should remain with your local primary care provider, if you have one, and we strongly encourage you to locate one if you do not.

Security Measures:

The electronic communication systems we use 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. All the Services delivered to the patient through telehealth will be delivered over a secure connection that complies with the requirements of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”).

In addition to these protocols, Your Provider will always be in a secure and private location to provide the Services. You must also be aware of your surroundings when receiving or participating in the Services. It is your responsibility to choose a location where your conversations with your Provider cannot be overheard by others.

You will need to connect to each session using a cellular data plan or a Wi-Fi network. We recommend that the Wi-Fi network you use require a password that is not publicly available or publicly displayed. Failure to use a secure Wi-Fi network increases the risk for a breach of the privacy and security of your medical information. Standard data and message rates will apply. (your practice name) will not reimburse you for costs associated with receiving the telehealth services.

You are required to tell your Provider your location at the beginning of each session, and have a backup phone number (e.g., a landline or other secondary phone) on file. This is to provide for your safety in the case of an emergency.

You agree to release (your practice name) from all claims, damages, losses, and expenses arising out of your failure to use a private and secure location and communication method while engaging in telehealth services, including, but not limited to, claims, damages, losses, and expenses arising from your use of an unsecure Wi-Fi connection.

Possible Risks:

- Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment and technologies, scheduling difficulty, or Provider availability.
- An inability to communicate as a result of a technological or equipment failure. If this is the case, please contact (your practice name) at (your practice email)
- In rare instances, your Provider may determine that the transmitted information is of inadequate quality, thus necessitating a rescheduled telehealth consult or an in-person meeting with your local primary care doctor.
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information.

Alternative Forms of Treatment

Instead of receiving teletherapy services from (your practice name) you may seek alternative forms of treatment. Alternative forms of treatment you might consider include in-person treatment, virtual treatment, and non-treatment. These alternatives may help to improve your condition(s), but they could also be ineffective compared with the teletherapy services rendered by (your practice name) Providers. Additionally, (your practice name) may not be able to provide you with an alternative form of treatment. If you have questions about available alternatives, ask your Provider.

CONSENT TO RECEIVE PROTECTED HEALTH INFORMATION VIA EMAIL AND SMS

You hereby consent and state your preference to have your (your practice name) Provider and other staff at (your practice name) communicate with you by email or standard SMS messaging regarding various aspects of your medical care, which may include, but shall not be limited to, test results, prescriptions, appointments, and billing.

You understand that email and standard SMS messaging are not confidential methods of communication and may be insecure. you further understand that, because of this, there is a risk that email and standard SMS messaging regarding your medical care might be intercepted and read by a third party.

CONSENT TO RECEIVE TEXT MESSAGES AND EMAILS FROM (your practice name) AND ITS BUSINESS PARTNERS

By providing your cell phone number and email address to (your practice name), you are agreeing to be contacted by or on behalf of (your practice name) and our business partners identified below at the email address and the telephone number provided, including emails to your email address and text (SMS) messages to your cell phone and other wireless devices, and the use of an automatic telephone dialing system, artificial voice and prerecorded messages, to providing you with marketing and promotional materials relating to (your practice name) products and services, and products and services of the identified business partners. You may opt-out of receiving text (SMS) messages from (your practice name) or its subsidiaries at any time by replying with the word STOP from the mobile device receiving the messages. You need not provide this consent in order to purchase any products or services from (your practice name). However, you acknowledge that opting out of receiving text (SMS) messages may impact your experience with the service(s) that rely on communications via text (SMS) messaging.

Business Partners: (your business partners)

ACKNOWLEDGEMENT AND ACCEPTANCE

The person checking the box below is the patient, the patient’s legal representative or is authorized by the patient to execute this form and accepts its terms.

By signing up and checking the box, I certify that I have received a copy of this Informed Consent to Treatment, that I have had an opportunity to ask questions about it, and that I understand its contents, including the nature of (your practice name) Services and the potential benefits, risks, and alternatives to such Services. Checking this box signifies my informed consent to receive the treatment described herein.

Signature*

(This will require your client's signature)

Date