OUTPATIENT TELEHEALTH INFORMED CONSENT

INFORMED CONSENT FOR BEHAVIORAL HEALTH AND TREATMENT SERVICES

Please carefully read this informed consent. It contains important information about your treatment and our policies. Federal and state law require that you understand your rights as a client/patient, or the legal guardian of a client/patient. When you sign this document, you acknowledge that you have read and fully understand the information below.

I, the undersigned, am requesting that Onlinemeditationevents ("OME") or True Self Center ("TSC") to provide me with evaluation and counseling treatment of the presented behavioral health condition (the "services").

1. CLINICIANS' CREDENTIALS. The clinicians at OME/TSC are licensed professionals engaged in providing behavioral health care services to clients directly. In each case, the clinician providing me with the services is appropriately licensed to provide these services based on their training and education.

2. THERAPEUTIC APPROACHES/TREATMENT OPTIONS.

a. Risks and benefits of behavioral health treatment. The health care services provided will be in accordance with generally accepted professional practices, and the specific approach utilized for my care will be chosen to best meet my needs and situation. I understand that behavioral health treatment may result in unexpected side effects, such as intense or uncomfortable emotions, and that it is important that I discuss any reactions to my treatment with my treating clinician. Behavioral health treatment can also provide benefits, such as a significant reduction in feelings of stress and improved self-esteem. I am aware, however, that the practice of behavioral health is not an exact science; no guarantees have been made to me about the results of treatments, examinations, or services.

b. Scope of care. OME/TSC counsels/treats patients needing counseling due to experiencing depression, anxiety, bereavement, grief, stress management, relationship issues, and similar conditions.

OME/TSC does not offer behavioral health services to:

Persons under the age of 21 or under the care of a legal guardian; Persons currently in a crisis situation; Persons who are actively suicidal or homicidal; Persons in need of emergency services, protective services, and/or hospitalization; Persons struggling with

current substance abuse disorders; Persons struggling with current eating disorders; Persons in need of legal assistance or forensic assessment; and others who are inappropriate to the telehealth services.

3. TELEHEALTH. Telehealth is not for everyone. All potential patients are screened for appropriateness via review of your intake form, your psychological history, and what symptoms and stressors you would like to address. Typically, determining appropriateness for telehealth services is a process and assessment may take place for up to three sessions. Therefore, please note that engagement in your first three sessions does not necessarily mean you are appropriate for ongoing telehealth services. Patients may either be transferred to a different clinician or provided with an outside referral if there is a clinically appropriate reason to do so. OME/TSC reserves the right to refuse services and provide appropriate referrals to anyone whose needs may be better served by another agency or provider or who is not appropriate for telehealth services (i.e. more appropriately served by in-person treatment). I understand that telehealth includes the practice of health care delivery, assessment, diagnosis, consultation, treatment, transfer of medical data, and psychoeducation using interactive audio, video, or data communications. I understand that, with my signed consent, telehealth may also involve the communication of my behavioral health information, both orally and visually, to other health care practitioners. **I understand that telehealth appointments are not intended as a substitute for emergency or crisis services; and agree that I will not use telehealth sessions in a medical emergency. I understand and agree that, in a medical emergency, I should dial 911, contact my own local health care practitioner, or visit an emergency room**.

a. Differences from in-person services. I understand that a telehealth appointment will not be the same as a face-to-face visit since I will not be in the same room as the clinician. I also understand that, because I will not be in the same room, the clinician will not be able to intervene if I attempt to self-harm during the telehealth appointment.

b. Technology. Video conferencing ("VC") is a real-time interactive audio and visual technology that enables the clinicians to provide health care services remotely. I understand that the technology used is designed to foster privacy protection, but that OME/TSC cannot guarantee privacy.

c. Risks and benefits of telehealth services. I understand that risks of receiving health care services via telehealth rather than in person in general may include (but are not limited to): the technology dropping due to internet connections, delays due to connections or other technologies, or a breach of my information that is beyond OME/TSC's control. Other

risks include discomfort with virtual face-to-face versus in-person services, and difficulties interpreting nonverbal communication. I also understand that there are many benefits to using telehealth services, such as the ability to receive care that I may not otherwise be able to access, receiving health care services in a comfortable setting, and reducing the need to travel to receive important health care services.

d. Alternatives to telehealth services. I understand and have been advised that there are alternative ways that I can seek and receive behavioral health care services, including in-person visits with a local health care provider in other facility.

e. My rights. I understand that I have the following rights with respect to telehealth:

i. I understand that I will need to download and use software designated by OME/TSC to participate in telehealth sessions. I further understand that I will be responsible for ensuring that for each telehealth session I will: 1) be in a private, comfortable, consistent, distraction-free location; 2) have a secure, working computer, tablet or cell phone with an internet connection and audio and video capabilities; 3) have a working telephone nearby in case the video conference connection is interrupted; and 4) have access to email and join the session on time.

ii. I have the right to withdraw my consent to receive services via telehealth at any time. If I do not withdraw my consent, my consent will continue for as long as I receive services from OME/TSC;

iii. I have a right to be informed of and made aware of the role and license information of the clinician providing the health care services, as well as other clinicians at OME/TSC that are responsible for follow-up or ongoing care;

iv. I have the right to be informed of and made aware of the location of my clinician and to have all questions regarding the equipment, technology, etc. being used addressed;

v. I have the right to have appropriately trained staff available to me while receiving health care services through telehealth to attend to emergencies and other needs;

vi. I have the right to be informed of all parties who will be present at each end of the telehealth transmission; and I have the right to request that services be provided in-person, but I understand that OME/TSC may not be able to comply with that request and may have to refer me to another provider at other facility that is able to provide services in-person.

4. PAYMENTS & FEES.

a. Financial responsibility. Subject to applicable law and the terms and conditions of any applicable contract between OME/TSC and a third-party payer, and in consideration of all

services rendered or about to be rendered to me, I agree to be financially responsible and obligated to pay OME/TSC for any balance not paid under the "Assignment of Benefits" paragraph below. Subject to applicable law, and in consideration of all health care services rendered or about to be rendered to me, I agree to be financially responsible and obligated to pay OME/TSC for the patient balances due.

b. Assignment of Benefits. In consideration of all services rendered or about to be rendered to me, I hereby assign to OME/TSC all right, title, and interest in and to any third-party benefits due from any and all insurance policies and/or responsible third-party payers of an amount not exceeding OME/TSC's regular and customary charges for the health care services rendered. I authorize such payments from applicable insurance carriers, third party payers, and other third parties. A list of usual and customary charges is available upon request. I consent to any request for review or appeal by OME/TSC to challenge a determination of benefits made by a third-party payer. Except as required by law, I assume responsibility for determining in advance whether the services provided are covered by insurance or another third-party payer. I understand that my current insurance must be on file with OME/TSC for my insurance to be billed and as such I will be expected to verify my insurance coverage prior to each telehealth session. If I do not provide OME/TSC with insurance information, I understand that I will be considered a self-pay patient and will be obligated to pay all fees associated with services rendered. I understand that failure to pay my balance may result in cessation of my relationship with OME/TSC, subject to the requirements of applicable law.

c. Fees for telehealth appointments. Fees associated with telehealth appointments are payable by credit or debit card. If fees may be associated with my telehealth services, I agree to have my credit/debit card information on file with OME/TSC. My card will be billed the same day as my scheduled telehealth appointment. If my card is declined, OME/TSC will cancel my appointment and I will be charged in accordance with the cancellation policy.

5. CONFIDENTIALITY. The laws that protect the confidentiality of my medical information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. I also understand that there are both mandatory and permissive exceptions to confidentiality including, but not limited to: reporting child, elder, and vulnerable adult abuse; expressed threats of violence toward an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. OME/TSC s telehealth platform is designed to protect my privacy and confidentiality. The manner in which OME/TSC can use and disclose my information is

further explained in the Notice of Privacy Practices, which I have received and acknowledged with my signature.

a. Telehealth and confidentiality. I understand that the electronic nature of telehealth health care services means that there is a greater risk to the privacy of my electronic health information relative to receiving health care services in person. By agreeing to receive telehealth health care services, I am consenting to OME/TSC's sharing of my protected health information with certain third parties as more fully described in OME/TSC's Notice of Privacy Practices, which governs any care I may receive. I understand, agree, and expressly consent to OME/TSC obtaining, using, storing, and giving to necessary third parties, information about me and my image, as necessary to provide me with health care services via telehealth. I further understand that records of the care provided to me via telehealth and other electronic communications from me are stored electronically and may be lost through technical failures. I hereby release and hold harmless OME/TSC, its clinicians, staff, and affiliates from any claim I may have as a result of any loss of data or information due to technical failures associated with telehealth.

6. SCHEDULING & CANCELLATIONS. I understand and agree that I am responsible for joining my session on time and at the scheduled time. I understand that if I miss a session without cancelling, or cancelling with less than 2-hours notice, a $25 penalty applies. I understand that these appointments cannot be billed to my insurance company and are my financial responsibility.

7. COMMUNICATIONS. By signing this informed consent, I am consenting for OME/TSC to communicate with me via mail, e-mail, and phone at the address and phone number I have provided. I agree that I will immediately notify OME/TSC of any changes in my contact information. I further agree to notify OME/TSC if I need to opt out of any form of communication. I understand that I am not receiving the direct email address of the practitioner providing services to me, and that, should I wish to speak to my provider, I should contact OME/TSC using the same method I used to set up my initial appointment or using any alternative contact information provided by OME/TSC. I understand that others within OME/TSC may have access to these communications but that I may request to speak with the provider of my choice.

8. NOTICE OF PRIVACY PRACTICES. I have received a copy of the Notice of Privacy Practices. The Notice of Privacy Practices explains how OME/TSC may use and disclose confidential health information that identifies me. I consent to let OME/TSC use and disclose health information about me as described in the Notice of Privacy Practices. In doing so, I consent to the release of my health information and financial account information to all third-party payers and/or their agents that are identified by OME/TSC, its

billing agents, collection agents, attorneys, consultants, and/or other agents that represent OME/TSC or provide assistance to OME/TSC for the purposes of securing payment from all parties who are potentially liable for payment for my behavioral health care. I understand that can revoke the consent described in this paragraph in writing at any time except to the extent that OME/TSC has already relied on my consent, and that revocation of my consent cannot prevent OME/TSC from making certain disclosures pursuant to the HIPAA Privacy Rule.

ACKNOWLEDGED AND AGREED:

I hereby voluntarily consent to all treatment and health care services that the clinicians at OME/TSC is considered to be necessary for me. These services may include therapeutic services. By signing this informed consent, I acknowledge that I have both read and understood all the terms and information contained herein. I agree that I received ample opportunity to ask questions and seek clarification of anything that remains unclear.

I further authorize OME/TSC to use telehealth in the course of my diagnosis and treatment. I have read and understand this consent and all of my questions have been answered to my satisfaction. I understand the risks, benefits, and alternatives of use of telehealth in behavioral health treatment and consent to its use.

Patient Name

Signature (patient or person authorized to sign for patient)

If authorized signer, full name and relationship to the patient

Date