I. DESCRIPTION, PURPOSE AND BENEFITS

I, as a patient, present myself or someone for whom I am legally authorized to consent to medical care, for an encounter with a physician or licensed designee to address a medical concern using telehealth. I have been informed that video conferencing equipment will be used to provide a physician or licensed designee encounter via electronic audio-visual communications and information technologies or other means, including interactive audio with asynchronous store-and-forward transmission, remote monitoring, and real-time interactive services. I understand that I may undergo a telehealth-appropriate physical evaluation consistent with my presenting symptoms. I further understand that I will have an opportunity to speak with the physician or licensed designee to ask questions. I have been provided with the contact information for the physician or licensed designee in my appointment information within the patient portal. This information may also be accessed through MaineHealth’s online Provider Directory at https://www.mainehealth.org/providers along with the provider’s licensure, certification, and credentials. My care may be provided by physicians, physician assistants, advanced practice nurses, registered nurses, licensed practical nurses, medical assistants, registered dietitians, licensed clinical social workers, psychologists, speech-language pathologists, pharmacists, and non-clinical care team members such as health coaches. In addition, physicians in training, including fellows and residents, as well as medical students, nursing students and other trainees acting under the supervision of attending physicians or supervisory nurses and other practitioners, may observe and may assist in diagnosis, treatment, and care.

I understand that individuals other than my healthcare providers may be present during the telehealth encounter to operate the video conferencing equipment. I further understand that I will be informed of the presence of any non-medical personnel in the encounter area and will have the right to request the following:

i. Omit specific details of my medical history/physical examination that are personally sensitive to me if the non-medical personnel need to remain in the encounter area;
ii. Ask non-medical personnel to leave the encounter area; and/or
iii. Terminate the telehealth encounter at any time.

I further understand that either my health care provider(s) or I can discontinue the telehealth encounter at any time if it is determined that the videoconferencing connections are not adequate to assess my particular medical situation in which case, I will be referred to another healthcare provider for an in-person evaluation.

II. LIMITATIONS AND RISKS ASSOCIATED WITH THE TELEHEALTH ENCOUNTER

I understand that certain limitations exist with a telehealth encounter including a provider’s ability to perform certain parts of a comprehensive physical assessment and certain diagnostic tests, as well as limitation on obtaining and transmitting certain clinical findings via video/audio. I understand that the physician or licensed designee conducting the telemedicine encounter may direct me to in person services, such as the Emergency Department or calling 911 if my condition requires this level of care. I further understand that telehealth is not suitable to provide a diagnosis and treatment plan for every medical condition. Additionally, the treatment of certain medical conditions may require the use of equipment not available in a telehealth encounter. For these reasons, my particular medical needs may require an in-person encounter with a provider. The physician or licensed designee performing the telehealth encounter (or their designee) will inform me whether a telehealth encounter is sufficient to render a diagnosis, or if further evaluation of my medical condition is needed, and whether treatment can be rendered via this modality.

I also have been informed that certain medications such as narcotics or other Drug Enforcement Agency (DEA) controlled substance medications may not be prescribed during a telehealth encounter. I further understand that while it may be possible for prescriptions to be ordered by the telehealth physician or licensed designee and to be picked up at a pharmacy, it may not be possible for me to receive medications that might typically be administered during an in-
person encounter, such as a vaccine. I also understand that electronic communication, including e-mails, electronic messages and other communications transmitted via telemedicine technologies, are not intended for urgent or emergency situations. My care team’s goal is to respond to my messages within 3 business days. If I need more urgent care, I will call the office or seek emergency care in the emergency department.

The physician or licensed designee performing the telehealth encounter also has explained to me that the usual and most frequent risks associated with this type of encounter include interruptions to Internet access and/or technical difficulties which may affect the clinical information obtained and transmitted or prematurely end the encounter; and unauthorized access to the videoconferencing equipment which may result in a breach of my protected health information.

III. ALTERNATIVE COURSES OF TREATMENT

The physician or licensed designee performing this telehealth encounter has explained to me the reasonable alternative treatment or procedures and, as appropriate, their usual and most frequent risks. I understand that the alternative to a telehealth encounter is a visit to another healthcare provider for an in-person evaluation, diagnosis and treatment which may not occur as quickly as a telehealth encounter can be performed.

IV. CONFIDENTIALITY AGREEMENT

When I participate in a telehealth encounter for group therapy, I understand that I will learn information of a confidential nature concerning other participants. I further understand the importance of maintaining the confidentiality of such information and agree to keep all information and experiences shared by other participants in the strictest confidence. In particular, I agree that I will not disclose to any third parties:

i. The name or identity of any participant;
ii. Any communications made by or about the participants; and
iii. Any other information that I may learn about the participants as a result of my involvement in this telehealth group therapy.

V. RELEASE/DISCLOSURE OF INFORMATION

I understand that MaineHealth’s policy is to maintain patient healthcare information as confidential and not to disclose such information unless the disclosure is permitted or required by law or I have authorized the disclosure. By law, patient healthcare information may be disclosed without an authorization to family or household members unless expressly prohibited by the patient or the patient’s authorized representative. I further understand that the healthcare practitioners responsible for this care may share my healthcare information orally or in writing with my family or household members involved in my care as necessary or directed by me.

I will be asked by my provider whether I agree to discuss my medical condition in the presence of any known visitors who may be in the room with me at the time of my telehealth encounter. If I do not wish for my medical condition to be discussed in the presence of visitors, then it is my responsibility to ask the visitors to leave the room during my telehealth encounter.
Due to the nature of a telehealth encounter, I understand that information may be collected, and passive tracking mechanisms may be utilized by the devices, equipment, and software used for telehealth visits. Information tracked may include, but is not limited to, clinical data for which I am being monitored, information to monitor device, equipment, or software performance for quality purposes, information related to my connection with the specific technology utilized in my telehealth encounter (i.e., my name, name of my provider, IP address, duration of the session, and various aspects related to hardware).

I UNDERSTAND, THAT BY LAW, HEALTH PROFESSIONALS AND MAINEHEALTH MAY DISCLOSE SOME HEALTH AND CLAIMS INFORMATION TO THIRD PARTIES AND THAT GENERALLY DISCLOSURES ARE LIMITED TO THE AMOUNT OF INFORMATION REASONABLY REQUESTED OR NEEDED.

I hereby authorize MaineHealth, members of its medical staff, healthcare practitioners and administrative personnel to make the following continuing uses and disclosures of information relating to my evaluation, diagnosis and treatment and claims data to the extent necessary:

- To primary care and other healthcare practitioners or facilities who have been or may become involved in my care both within and outside the State of Maine including via Epic Care Everywhere, a tool that MaineHealth uses to exchange data with other providers in real-time to share pertinent clinical information to assist in the delivery of care, especially in emergency situations; to clinical and non-clinical personnel who may now or in the future become involved in both the management and transition of my care between hospitals, medical practices, other healthcare facilities and home including care coordination and case management services; and for other lawful functions;
- To outside organizations that carry out benchmarking functions for quality and cost performance, utilization review, and comparison of health care interventions to determine which work best for certain patient populations for my healthcare providers, with the understanding that I will not be individually identified in any reports from these organizations;
- To individuals, companies and governmental agencies that may be responsible for paying for my care including insurance carriers and their health claim reviewers. This authorization is effective until final payment is received or 30 months from today (whichever is sooner);
- To contracted agents for the identification of current and potential third-party resources available for payment of services, determination of a patient’s eligibility or coverage in a health benefits plan, and provision of related advocacy initiatives to access insurance benefits or other resources; and
- To HealthInfoNet (HIN), a state-wide arrangement of healthcare organizations who have agreed to work with each other to make available electronic health information that may be relevant to my care and to an out-of-state health information exchange, the eHealth Exchange. I understand that I may choose to not make my health information available to HIN and to the eHealth Exchange by completing the paperwork provided to me during the registration process and sending it to HIN at the designated address.
- Photographs and videos may be made for the purposes of diagnosis, teaching, quality improvement, and documentation within the MaineHealth system. Video recordings may include my newborn’s treatment. I acknowledge that these audiovisual recordings may be reviewed by staff members involved in quality improvement activities but will not become part of my medical record and will be erased after review. I understand that given the purpose of these recordings they will not be made available for review by me, or others not involved in these quality improvement activities. I reserve the right to give specific permission for the external publication of any image that personally identifies me.
I understand that:

- If I do not wish to have my health information disclosed via Epic Care Everywhere, then I may opt-out by completing the form available online at https://careeverywhere.mainehealth.org.
- I may request in writing to revoke all or part of these authorizations at any time by notifying MaineHealth in writing. I understand that the revocation shall not apply to any disclosures made prior to receiving notice of the revocation.
- HIPAA provides the opportunity to request limits on the disclosure of your health information. However, HIPAA does not require that MaineHealth agrees to all such requests. Information recorded in an electronic health record cannot always be easily isolated from further use or disclosure. If MaineHealth is able to agree to such requests, I understand that MaineHealth may still disclose the information when needed to provide you with emergency treatment or when required by law and that in some circumstances disclosures may occur despite the MaineHealth’s efforts to restrict them. MaineHealth is required to agree to your request to not provide your insurance carrier with your health information if you have paid in full for the health care services.
- The refusal or revocation of my authorization to release some or all information may result in either delayed or improper diagnosis or treatment, denial of insurance coverage or a claim for health benefits, or other adverse consequences.
- I may request a copy of this form.
- This authorization is effective for one (1) year from the date of signing. I authorize future disclosures to the same individual and/or entities during this time period.

VI. SPECIALIZED RELEASES FOR SENSITIVE HEALTH INFORMATION

If I have been diagnosed or treated for HIV or diagnosed or treated by a mental health or substance use disorder treatment program, I understand that MaineHealth usually will obtain my specific consent on a separate authorization form to disclose related information outside of MaineHealth.

I hereby agree to the disclosure of all substance use disorder information including, without limitation, medications, substance use history, employment information, living situation, and social supports to my treating providers as well as participating accountable care organizations and health information exchanges for purposes of care coordination and case management services.

References to sensitive health information may nevertheless be available to authorized users within the Shared Electronic Health Record (SeHR) including the problem list, medication list, diagnosis and allergy fields, and such information may also be available to MaineHealth’s medical staff, healthcare practitioners and administrative personnel for the purposes of: (i) my evaluation, diagnosis or treatment to ensure quality of care and patient safety; (ii) to complete the responsibilities of the healthcare practitioners involved in my evaluation, diagnosis or treatment; (iii) inclusion in continuity of care documents for planned and unplanned transitions of care; and (iv) payment of the costs associated with my evaluation, diagnosis and treatment; I hereby consent to such disclosures. The availability of such information for these purposes is limited by both technological access controls and internal protocols, and also is subject to auditing.
VII. BILLING FOR THE TELEHEALTH CONSULT

I understand that billing for this telehealth encounter will consist of both a consulting fee from the physician or licensed designee performing the telehealth encounter and may also consist of a facility fee from the site. Other than the fees for the provided services, the physician or licensed designee does not have any additional financial interests when providing telehealth services. I further understand that I am responsible for paying all costs associated with my evaluation and care. If I have health insurance, I understand that I am financially responsible in the event that all or some payment is denied by my insurance carrier or another third party who is responsible for payment. I also am responsible for those charges not covered by my insurance, such as deductibles, co-pays, or evaluations or treatment that are not included as an insurance benefit. This includes services rendered to me that may not meet medical necessity as defined by my insurance carrier.

I authorize my health insurance carrier(s) or other financially obligated third parties, including Medicare and Medicaid, to pay the costs associated with my evaluation and care directly to the facility, clinic or practice and members of the Medical Staff involved in my care, and as part of this authorization, I assign to MaineHealth and members of the Medical Staff involved in my care my rights to receive reimbursement under any applicable insurance policy, or program or plan for my obligations to pay for such care. I further authorize the facility, clinic, or practice to release information relating to the billing and filing of claims for reimbursement for medical care delivered to me to the health care provider responsible for the cost of my care and to ambulance units who transport me to a MaineHealth hospital or a MaineHealth affiliate. I understand that this authorization will remain valid for one (1) year, or until payment is received, whichever occurs later.

I acknowledge that I have read this document carefully, that I understand the limited nature, benefits, risks and alternatives to this telehealth encounter, and that I have had ample time to ask questions and to consider my decision. I hereby consent to participate in the telehealth services described herein for purposes of examination, encounter, diagnosis, and treatment.

Date Time AM|PM Signature □ Patient □ Parent □ Guardian □ Authorized Representative Printed Name

Date Time AM|PM Witness Signature Printed Name

Interpreter Printed Name Interpreter Signature