

HUMN MEDICAL ASSOCIATES PC

Consent to Treatment Using Telehealth Technology

Consent to Receive Communications by Email and Text Message

Refund Policy

Patient Name:	Date of Birth:
Address:	

IMPORTANT NOTICE: DO NOT USE THESE SERVICES FOR EMERGENCY MEDICAL NEEDS. IF YOU ARE EXPERIENCING A MEDICAL EMERGENCY, YOU SHOULD DIAL “911” IMMEDIATELY AND/OR GO TO THE NEAREST EMERGENCY ROOM.

1. Services Provided.

HUMN Health LLC (“**HUMN Health**”) provides certain non-clinical administrative services and licenses technology to HUMN Medical Associates PC, an independent wellness practice (the “**Practice**”), and their engaged health care providers (“**Providers**”). The Practice and Providers use HUMN Health’s technology platforms to assist them in providing their patients various health care services through the use of Telehealth Technology (defined below). HUMN Health does not diagnose or treat any condition, provide any health care service, or assert any influence over the Practice or any Provider. HUMN Health is a business associate service provider to the Practice and does not own or operate the Practice or employ, engage or supervise any Provider, each of whom are solely responsible for all health care decisions.

The Practice and its Providers furnish health care services via telehealth technology, including the use of synchronous (real-time, two-way) and/or asynchronous (recorded, store-and-forward) audio-visual electronic communications technology to enable a health care provider and a patient at different locations to communicate and share individual patient health information for the purpose of rendering or receiving clinical health care services (“**Telehealth Technology**”). This “Consent to Treatment Using Telehealth Technology” describes the benefits, risks, and limitations of using Telehealth Technology and gives you the Patient (“**I**”, “**Me**,” “**My**,” “**You**,” and “**Your**”) an opportunity to provide Your consent to treatment by the Practice and its Providers via Telehealth Technology.

The services offered by the Practice and its Providers through Telehealth Technology may include appointment scheduling, intake documents and questionnaires, patient evaluation, assessment, diagnosis, treatment recommendation, education, care management, issuing prescriptions and orders, and/or a referral to in-person care, as determined clinically appropriate by the Provider (the “**Services**”). Depending on your state laws, Providers may include physicians, nurse practitioners, physician assistants, dietitians, health coaches, diagnostic analysts, wellness strategists, and other care providers.

The Practice offers Services in all 50 states of the United States.

The Practice has an in-person clinic located at 337 B S. Cumberland St., Lebanon, TN 37087.

2. Risks and Benefits of Telehealth Technology.

A primary benefit of using Telehealth Technology is that it may help to improve access to care and the quality of outcomes because using Telehealth Technology may make it easier for Providers and patients to connect and to manage the patient’s care. There are, however, risks to using Telehealth Technology and for both health care services delivered in-person and for services delivered via Telehealth Technology, results cannot be guaranteed.

The risks associated with Telehealth Technology include, and are not limited to, technical problems and equipment malfunctions that may result in omission, loss or compromise of information necessary for Your care, and that such omission, loss or compromise of information may result in damages or injury to You. Your health information, and treatment information transmitted via Telehealth Technology may be accessed by unauthorized persons. Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment and technologies, or Provider availability. In some cases, Your Provider may determine that the transmitted information is of inadequate quality, thus necessitating a rescheduled telehealth consult or a referral for in-person services from an alternative provider.

3. Treatment Acknowledgement and Consent.

- a. I authorize and request that the Practice and its Providers carry out a review and assessment of my health history including scans and tests to recommend testing or treatment, and/or diagnostic procedures, which now or during the course of my care as a patient are advisable. I understand that the purpose of these procedures will be explained to me upon my request and furnished subject to my agreement and that I will be informed of available alternative treatments, if any.
- b. I understand that I can always change my mind regarding my treatment, however, I will notify my Provider(s) before making such a decision as there may be adverse side effects of stopping certain medications.
- c. I understand that I have the right to accept or refuse the recommended therapeutic or diagnostic procedures. I understand that I have the right to revoke this consent at any time.

4. Telehealth Technology Acknowledgement and Consent

- a. I hereby consent to evaluation, diagnosis, and treatment by the Practice and its Providers through the use of Telehealth Technology. I acknowledge that evaluation, diagnosis, and treatment through the use of Telehealth Technology will involve collecting health information, about Me and My health care and health care condition, and that such information will be transmitted, reviewed and stored in compliance with applicable laws.
- b. I acknowledge that receiving Services using Telehealth Technology requires My health information to be transmitted through audio and video technology and that My health information may be lost, compromised and/or accessed by unauthorized persons during transmission.
- c. I understand that I have a right to withhold or withdraw My consent to the use of Telehealth Technology in the course of my care at any time, and that doing so may terminate my care by the Practice if alternative communication methodologies are not available.
- d. If I am experiencing a medical emergency, I have been directed to dial 9-1-1 immediately and that my Provider is not able to connect me directly to any local emergency services.
- e. I may elect to seek services from an unaffiliated wellness group with in-person clinics as an alternative to receiving care via Telehealth Technology.
- f. In choosing to receive Services via Telehealth Technology, I understand that some parts of the Services involving tests (e.g., labs or bloodwork) may be conducted at another location such as a testing facility, at the direction of my Provider.
- g. It is necessary to provide my Provider a complete, accurate, and current medical history. I understand that withholding or providing inaccurate information about My health and medical history in order to obtain treatment may result in harm to Me, including, in some cases, death.
- h. There is no guarantee that I will be treated by a Provider and that I may need to seek care and treatment in-person or from an alternative source. The Practice reserves the right to deny care for potential misuse of the Services or for any other reason if, in the professional judgment of my Provider, the provision of the Services

is not medically or ethically appropriate.

5. Telehealth Technology Waiver and Release.

ON BEHALF OF MYSELF AND MY RELATIVES, HEIRS, REPRESENTATIVES AND ASSIGNS I HEREBY WAIVE AND RELEASE ALL CLAIMS THAT I MAY HAVE NOW OR IN THE FUTURE AGAINST HUMN HEALTH LLC, AND/OR HUMN MEDICAL ASSOCIATES PC AND ITS PROVIDERS FOR DAMAGE OR LOSS IN CONNECTION WITH THE RISKS INHERENT IN EVALUATION, DIAGNOSIS, AND TREATMENT USING TELEHEALTH TECHNOLOGY, INCLUDING, BUT NOT LIMITED TO, TECHNICAL PROBLEMS, EQUIPMENT MALFUNCTIONS, AND OMISSION, LOSS, COMPROMISE OR UNAUTHORIZED ACCESS TO HEALTH INFORMATION ABOUT ME TRANSMITTED THROUGH TELEHEALTH TECHNOLOGY.

I understand and agree to the forgoing and all of my questions regarding its content have been answered.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE:	IF NOT PATIENT, PRINT NAME & CONTACT INFORMATION OF PERSONAL REPRESENTATIVE SIGNING THIS FORM:
DATE:	DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY TO ACT ON BEHALF OF PATIENT:

6. Consent to Electronic Communications; Opt-Out.

By providing Your mobile telephone number and/or email address to HUMN Health, the Practice or a Provider, You consent to and authorize us to communicate with You via email and/or text messaging.

Neither HUMN Health, the Practice nor any Provider can ensure the confidentiality of any form of electronic communication, including email or text messages. If You consent to receive electronic communications from HUMN Health, the Practice or any Provider, please know that information communicated electronically may be lost, damaged or subject to unauthorized access. While the Practice asks Providers to return messages in a timely manner, neither HUMN Health nor the Practice can guarantee a timely response or any response at all. Due to the inherent security risks of electronic communications and unreliability of Provider responsiveness, HUMN Health and the Practice request that You do not use these methods of communication to discuss diagnosis or treatment with your Provider.

If You wish to opt-out of receiving email and/or text messages from HUMN Health, the Practice or a Provider, please notify us at: support@humnhealth.com. Please allow up to two business days for Your request to opt-out of electronic communications to become effective.

I understand and agree to the forgoing and all of my questions regarding its content have been answered.

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DATE:	DESCRIPTION OF PERSONAL REPRESENTATIVE'S AUTHORITY TO ACT ON BEHALF OF PATIENT:

7. Refund Policy

NO REFUNDS. The Practice does not refund any amounts paid for service.

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