Forward INTEGRATED SERVICES

Integrated Support and Training for Caregivers and the Community, One Skill at a Time.

Telehealth Consent Form

Client's Name:______________________________

Informed consent is a legal status wherein you, (the "Client") of Forward Integrated Services, Inc. (herein referred to as FIS Inc., the "Provider"), confirm that you have personally, or on the behalf of your child or individual of which you are a legal guardian, made a voluntary and educated choice to receive services. This document is intended to provide you with important information regarding the practices, policies, and procedures of FIS Inc., and to clarify the terms of the professional relationship.

Introduction

Telehealth, sometimes referred to as Remote Service Delivery, involves the use of electronic communications to enable providers at different locations to share Patient information for the purpose of improving Patient care. Providers of telehealth services may include state-licensed and/or nationally-certified FIS Inc. team members and other providers who are part of my family support team. In addition to myself and the members of my team, my family members, caregivers, or other legal representatives or guardians may join and participate in the telehealth session, and I agree to share my personal information with such family members, caregivers, legal representatives or guardians. The information may be used for training/support, follow-up, and/or education and may include any of the following:

- Patient Medical Records
- Progress reports
- Live two-way audio and video
- Telephonic communication
- Output data from health applications, sound and video files

Real-time Videoconferencing Telehealth

Real-time videoconferencing consists of face-to-face provider and patient interactions that occur in real-time via a two-way video and audio interactions. Under this model, a FIS Inc. professional will render services directly to you in your home or community either in-person or via real-time video conference technology. Family support and team meetings will occur in the same format.

Video Store-and-Forward Telehealth

Video store-and-forward includes transmission of video and audio interactions to a provider at another site. As part of our service model, we may review videos of sessions to evaluate Patient's response to services. Videos will be stored for 7 years on our HIPAA compliant server.

Expected Benefits

- Improved access to care and support by enabling a Patient to remain in their home (or at a community-based site) while the Provider consults at distant sites.

- More efficient evaluation and clinical management.
- Increased ability to observe behaviors occurring within a natural environment.
- Obtaining expertise of a distant specialist.

Possible Risks: As with any medical/behavioral health service, there are potential risks associated with the use of telehealth. These risks include but are not limited to:

- In rare cases, information transmitted may not be sufficient (e.g., poor resolution of images) to allow for appropriate decision making by the Provider.
- Delays in services 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 health information.

Patient Consent to The Use of Telehealth

I have read and understand the information provided above regarding telehealth, have discussed it with my Provider, FIS Inc. team member, or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth in my health care:

- ☐ Real-Time videoconferencing telehealth
- ☐ Video store-and-forward telehealth

If you selected video store-and-forward Telehealth, please select every purpose you consent to:

- ☐ Regular video reviews by a team of professionals in our organization
- ☐ Internal training seminars for professionals
- ☐ For the purpose of teaching the Patient (video modeling)
- ☐ All of the above uses are approved
- ☐ None of the above uses are approved

By signing this form, I understand the following:

1. I understand that an adult who has medical treatment authorization must be present during all telehealth sessions in case of an emergency. Telephone numbers for fire, police, poison control, and the nearest medical facility must be listed in plain sight should they need to be accessed. In the event of any emergency, a 911 call must come from the session site.
2. I understand that the laws that protect privacy and the confidentiality of medical (including behavioral health) information also apply to telehealth, and that no information obtained in the use of telehealth which identifies me will be disclosed to any third party without my consent, except when required under law.
3. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future

care or treatment.

4. I understand that I have the right to inspect all information obtained and recorded in the course of a telehealth interaction, and may access much of this information through FIS Inc.'s secure patient records system
5. I understand that a variety of alternative methods of behavioral healthcare may be available to me, and that I may choose one or more of these at any time. FIS Inc. has explained the alternatives to my satisfaction.
6. I understand that telehealth may involve electronic communication of my personal health information to other practitioners who may be located in other areas, including out of state.
7. I understand that it is my duty to inform my Provider of electronic interactions regarding my care that I may have with other healthcare providers.
8. I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.

I hereby authorize Forward Integrated Services Inc. to use telehealth in the course of my treatment.

_______________________________________ __________________

Signature of Patient or Patient's Legal Representative | Date and Time

_______________________________________ __________________

Printed Name of Patient or Patient's Legal Representative | Relationship to the Patient

INTERPRETER'S ATTESTATION (if applicable): I certify that I am fluent in the language of the person providing consent. I certify that I have accurately and completely interpreted the contents of this form, and that the person giving consent has indicated their understanding of the contents.

_______________________________________ __________________

Signature of Interpreter | Date and Time

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