Central Outreach Wellness Center - PrEP2Me.com

95 Leonard Ave. Suite 203 - Washington, PA 15301 | 127 Anderson Street - Pittsburgh, PA

INFORMED CONSENT – TELEMEDICINE/PrEP and PEP

PERSONAL INFORMATION:

First Name: _____ Last Name: _____

Date of Birth: _____ Gender: _____

Street Address: _____ (Apt #: _____)

City:_____ County: _____ State: _____ Zip Code: _____

Phone Number: (_____)-_____-_____ Phone Number: (_____)-_____-_____

Email: _____

TELEMEDICINE INFORMED CONSENT:

- I have read, or someone has read and explained to me, the information provided by Central Outreach Wellness Center t/d/b/a PrEP2Me.com ("COWC") regarding the transmission of HIV, other STIs, Pre-Exposure Prophylaxis (PrEP) medication, Post-Exposure Prophylaxis (PEP) medication and the purposes, potential uses, limitations, complications and benefits of PrEP and PEP medication.
- I have read, or someone has read and explained to me, the information provided by COWC regarding the policies and procedures for telemedicine treatment of STIs, HIV, including but not limited to, the telemedicine procedures for the provision of HIV testing, PrEP medication and PEP medication.
- I understand and acknowledge that telemedicine services provided by COWC, are limited to HIV and other STIs treatment, including the provision of HIV testing, PrEP medication and PEP medication and are only available to residents of Ohio and Pennsylvania. I hereby represent and certify that I am either a resident of the State of Ohio or a resident of the Commonwealth of Pennsylvania and am of legal age and competence to obtain the COWC services.
- I have read, or someone has read and explained to me, the Terms of Service and Disclaimer located on the website www.PrEP2Me.com and I consent to the terms and conditions contained therein.
- I understand and acknowledge that telemedicine involves the use of electronic communications to enable healthcare providers at different locations to share my medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. I acknowledge that the information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:
    - Patient medical records
    - Medical images
    - Live two-way audio and video
    - Output data from medical devices and sound and video files
- I understand that patient care other than for STIs, HIV, PrEP, and PEP will not be provided by COWC. I may choose COWC or other health care providers to provide follow-up care for STIs, HIV, PrEP, and PEP. Upon patient's consent, COWC will forward the medical records to the patient's identified primary care provider or other health care providers, or refer the patient as appropriate. COWC may provide prescriptions for STIs, HIV, PrEP, and PEP and a diagnosis and treatment plan as appropriate.
- I understand and acknowledge that the expected benefits of telemedicine are:
    - Improved access to medical care by enabling me to remain in my home while my healthcare provider consults and obtains test results at distant/other sites.
    - More efficient medical evaluation and management.
    - Obtaining expertise of a specialist.

- I understand and acknowledge that there are potential risks associated with the use of telemedicine. These risks include, but are not limited to:
    - In rare cases, the healthcare provider may determine that the transmitted information is of inadequate quality, thus necessitating a face-to-face meeting with the patient, or at least a rescheduled telemedicine consult;
    - Delays in medical evaluation and treatment 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 medical information;
    - In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors.
- I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine, which identifies me, will be disclosed to researchers or other entities without my written consent.
- I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
- I understand the alternatives to telemedicine consultation as they have been explained to me, and in choosing to participate in a telemedicine consultation, I understand that some parts of the exam involving physical tests may be conducted by way of at-home testing kits, or at a testing facility, at the direction of a healthcare provider.
- I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
- I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than healthcare providers in order to operate the communications equipment. The above-mentioned people will maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room; and/or (3) terminate the consultation at any time.
- I have read this document carefully, and understand the risks and benefits of a telemedicine consultation and have had my questions regarding the procedure explained and I hereby give my informed consent to participate in a telemedicine consultation under the terms described herein, including but not limited to telemedicine examination and remote testing and treatment for HIV, and other STIs, including all examinations and tests relating to PrEP and PEP medications.
- I have read, or someone has read and explained to me, the process for complaints related to healthcare services provided via telemedicine by COWC. I understand that all complaints related to telemedicine shall be submitted in writing to COWC at 127 Anderson Street, Suite 101, Pittsburgh, PA 15212. I consent to COWC contacting me via the telemedicine procedures currently used by COWC, email, text message, and/or Facebook messenger in the event additional patient consent is needed for additional healthcare procedures or testing.

HIPAA INFORMATION AND CONSENT:

- I understand and agree that COWC, its employees and healthcare providers, will use and disclose my healthcare information in order to: (1) make informed decisions, refer to, consult with, coordinate among and manage my health information regarding my medical care and treatment; (2) determine my eligibility for PrEP and PEP treatments and medication, patient assistance programs, specialty pharmacy services, health plan benefits or insurance coverage; (3) coordinate with my insurance provider or other parties who may be responsible to file claims concerning billing , laboratory services, prior authorizations and other medical benefits; and (4) perform various office, administrative and business functions that support my medical providers' efforts to provide me with quality, cultural competent, cost effective healthcare.
- I understand that my health information may include details that pertain to health history and status, symptoms, examination, testing, diagnosis, and treatment plans including PrEP and PEP treatments, procedures, prescriptions, etc. I understand that my health information may exist in formats created and/or received by COWC; and may exist in written, spoken, or electronic forms.

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- I consent to have COWC communicate with me via the telemedicine procedures currently used by COWC, email, text message, and/or Facebook messenger regarding my medical care and treatment. I understand that in some instances this correspondence may not be a confidential method of communication. I further understand that there is a potential risk that this communication between COWC, its employees and healthcare providers, and myself, the patient, regarding my health information may be intercepted by third parties or transmitted to unintended parties. I understand that in an urgent or emergent situation, I should contact my healthcare provider directly or proceed to the Emergency Department and therefore am not solely relying on this type of communication.
- I understand that I reserve the right to review how COWC handles my health information, in regard to use and disclosure. I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described above; however, I understand that COWC is not required by law to agree to such a request.
- I acknowledge, as a patient of COWC under the direction of Dr. Stacy Lane DO, that I authorize COWC, Dr. Stacy Lane, DO and all health care providers at COWC, to speak on my behalf to any and all entities (including specialty pharmacies, physicians, etc.) in the management of my healthcare. Furthermore, I waive the right to be counseled by any pharmacy and I authorize Dr. Stacy Lane, and all other COWC healthcare providers to direct all aspects of my healthcare.
- I acknowledge my rights as patient; which have been provided to me and are available to me upon request. I understand that any health information form for inter-office or intra-office use may be revised from time to time and that I am entitled to receive a copy of any revised forms.

Intending to be legally bound hereby, the Applicant or the Applicant's authorized representative has executed this Telemedicine Informed Consent and HIPAA Consent.

Signature of Applicant: _____ Date: _____

AUTHORIZED REPRESENTATIVE:

Representative Name: _____

Representative Address: _____

City:_____ County: _____ State: _____ Zip Code: _____

Phone Number: (_____)-_____-_____

Signature of Authorized Representative : _____

Date: _____