LUMA
HEALTH CO.

TELEHEALTH INFORMED CONSENT FORM

Healthcare services are available to the patient from Luma Health Co., 504-336-6164 info@lumahealthco.com ("Practice") by use of secure interactive videoconferencing equipment and devices that enable Practice's treatment providers to deliver health care services to patient when each of patient and treatment provider are located at different locations. This process is referred to as "telehealth." Telehealth involves the use of electronic communications to enable licensed healthcare professionals (collectively, the "Treatment Provider") at different locations to share individual patient clinical information for the purpose of improving patient care. The information may be used for healthcare delivery, diagnosis, treatment, transfer of clinical data, therapy, consultation, follow-up and or/education and may include patient clinical records and live two-way audio and video. Electronic systems used will incorporate network and software security protocols to protect the privacy and confidentiality of patient identification and information. It is important that you understand and agree to the following statements to understand your rights and responsibilities while receiving care from Treatment Provider.

EXPECTED BENEFITS:

1. Improved access to healthcare by enabling patient to remain at a remote site while consulting with Treatment Provider;
2. More efficient healthcare evaluation and management; and
3. Obtaining the expertise of a distant specialist.

POSSIBLE RISKS:

Although rare, there are potential risks associated with the use of telehealth. These risks include, without limitation:

1. Information transmitted may not be sufficient (i.e., poor connection) to allow for appropriate clinical decision making by the Treatment Provider and consultant(s);
2. Delays in evaluation and treatment could occur due to technical deficiencies or failures;
3. The transmission of patient's clinical information could be interrupted by unauthorized persons, and/or the electronic storage of patient's clinical information could be accessed by unauthorized persons; and
4. A lack of access to complete clinical records may result in judgment errors.

ALTERNATIVE METHODS:

A variety of alternative methods of clinical care may be available. A patient may request alternative methods of care to telehealth from Treatment Provider. Telehealth based services and care may not be as complete as face-to-face services. There are potential risks and benefits associated with any form of treatment, and despite patient efforts and the efforts of Treatment

Provider, a condition may not improve and in some cases may worsen. If it becomes clear that the telehealth modality is insufficient to provide adequate treatment, the Treatment Provider will make recommendations to the patient for further care.

TELEHEALTH BY SIMPLEPRACTICE SERVICE

Telehealth by is the technology service the Practice and Treatment Provider will use to conduct the telehealth appointment. It is simple to use and there are no passwords required to log in. By signing this document, I acknowledge:

1. Telehealth by Simple Practice is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
2. Though my Treatment Provider and I may be in direct, virtual contact through the Telehealth by Simple Practice, Telehealth by Simple Practice does not provide any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services. The medical advice, care and healthcare services are provided by the Treatment Provider
3. The Telehealth by Simple Practice Service facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.
4. My Treatment Provider does not have access to any or all of the technical information in the Telehealth by Simple Practice Service I will not rely on my Treatment Provider to have any of this information in the Telehealth by Simple Practice Service.
5. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

By signing this form, I understand the following:

1. I understand telehealth is the use of electronic information and communication technology to deliver healthcare services including, without limitation, the assessment, diagnosis, consultation, treatment, education, care management and/or self-management of a patient, when the patient is located at a different site than the Treatment Provider. As such, I understand that I will not physically be in the same room as my Treatment Provider.
2. I understand I will be notified if persons other than Treatment Providers will be present on the telehealth consult/visit. I further understand that there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties that may lead to an inability to obtain information sufficient for decision making about my health problem and that all reasonable precautions will be taken to minimize these risks. I understand that either my Treatment Provider or I can discontinue the telehealth consult/visit if it is determined that the videoconferencing connections are not adequate for the situation.
3. I understand that Treatment Provider may include, without limitation, a licensed nurse practitioner or other healthcare professional. The information may be used for healthcare

delivery, diagnosis, treatment, transfer of clinical data, therapy, consultation, follow-up and/or education and may include patient clinical records and live two-way audio and video. Electronic systems used will incorporate network and software security protocols to protect the privacy and confidentiality of patient identification and information.

4. I understand the same standard of care applies to a telehealth visit that applies to an in-person visit. I further understand that my medical records of telehealth services will be kept at the Practice.
5. I understand the federal and state laws that protect privacy and the confidentiality of clinical information also apply to telehealth. I understand the information disclosed by me during the course of my treatment is confidential; however, there are both mandatory and permissive exceptions to confidentiality, including, without limitation:
    a. information demonstrating a probability of imminent physical injury to myself or others;
    b. suspicion of abuse of a child, elder, or individual with a disability; or
    c. if my clinical records are court ordered by a judge.
6. I understand 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.
7. I understand I may expect the anticipated benefits from the use of telehealth in the course of my care, but no results can be guaranteed or assured.
8. I understand that in the event of an adverse reaction to the treatment or in the event of an inability to communicate as a result of a technological or equipment failure, I shall call 911 or seek follow-up care or assistance by contacting the Practice.
9. I understand by providing a telephone number above, I agree that Treatment Providers and other agents of Practice involved with the provision of telehealth services may contact me about appointment reminders, surveys, follow-up care, obtaining potential financial assistance for my account(s), and to bill and collect any amounts I may owe. I expressly acknowledge and consent that methods of contact may include SMS text messages, phone calls, automated technology such as an auto-dialing device, prerecorded messages and artificial voice messages, as applicable.
10. I agree to make available evidence that I am currently residing in the state listed above, and to inform my Treatment Provider immediately of any changes to my residency.
11. I agree to secure a non-public environment for the duration of my telehealth sessions, including, without limitation, to the following criteria: quiet, well-lit, enclosed area with minimal distractions and headphones/earbuds available. I will ensure the privacy and confidentiality of my sessions by attending in a private setting.
12. I understand in case of a life-threatening emergency that I am to call 911 immediately (not the Treatment Provider or Facility). If an emergency occurs during an active telehealth encounter, I should remain on the video connection (if possible) after calling 911 until help arrives.
13. I understand that for non-urgent questions or concerns, I may send a secure message directly to Treatment Provider through the Simple Practice portal. Messages will be reviewed during normal business hours and are not continuously monitored.

14. I understand that I may request a copy of my medical records by submitting a written request to the Practice administrator at info@lumahealthco.com.
15. I understand that Telehealth by Simple Practice is the technology service the Practice and Treatment Provider will use to conduct the telehealth appointment.
16. I understand that my Treatment Provider will be Tiffani McKnight, Family Nurse Practitioner (Louisiana License Number: LA 203668; also licensed in 30+ other states, license info available upon request). The Practice may assign another Treatment Provider for the telehealth visit as it may deem necessary.

PATIENT CONSENT TO THE USE OF TELEHEALTH:

By signing this form, I attest to the following:

- I have personally read or had this form read (or had this form explained to me);
- I am not subject to any medication, illness or other impairment that might affect my ability to comprehend or understand this consent.
- I fully understand its contents including the risks, benefits and alternatives to telehealth visits.
- I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.
- I am located in the state listed above and will be in that state during my telehealth visit(s).
- I have received a copy of this consent and the Practice's Notice Of Privacy Practices.
- I hereby authorize Practice, Treatment Provider and its authorized agents to use telehealth in the course of my diagnosis and treatment.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Patient: _____ Date of Birth: _____

Patient Signature: _____ Date: _____