Electronic -Medical Consultation Consent

Electronic consultation/medical service consent
Authorization to Disclose and share Protected Health information / Medical Records over electronic media
Authorization for Payment for any applicable service fees
Electronic Delivery Request

I, am a patient or a parent and /or Legal Guardian of child receiving services at Apple Pediatrics- Bodhi Medical Care, LLC and:

I understand that Bodhi Medical Care, LLC offers an optional electronic consultation to provide medical advice or medical support for established patients or parents (or legal guardians) of child(children) established to the practice pertinent to any medical concerns for which I, the patient, parent (or legal guardian) wish to consider and request electronic consultation over actual outpatient medical visit. I, the patient or parent(s) (or legal guardian) understand that this electronic consultation is an actual medical service which besides its benefit such as being provided with medical advice without medical visit, saved time and other benefits has also its limitations including lack of direct provider to patient interaction, inability to conduct direct medical exam and other limitations which may arise as a result of an electronic communication over actual medical visit. I, the patient, parent (or legal guardian) understand to be selecting such service as an option and that there is always available option of direct medical visit. Appointments for in office – direct medical visits are available to be made 24/7 online at www.mybodhi.com. If in need of further assistance, Apple Pediatrics - Bodhi Medical Care, LLC can also reached over the phone at 8886030993 (for pediatric services) and 8886039338 (for adult services) or for general inquiries via email at yourdoctor@mybodhi.com .

Furthermore, I, the patient or parent (or legal guardian) understand that the provider I select for this optional service has to rely on information provided by me and that failure to provide complete or additional information may result in reduced ability or inability to provide complete consultation or complete medical advice. I understand that such medical advice provided by selected medical provider of Apple Pediatrics-Bodhi Medical Care, LLC does not guarantee any cure, improvement or success of any medical advice and that limitations of such medical advice exist. I understand that as a result additional recommendation may include need for additional communication, additional consultation, an actual outpatient medical visit or additional recommendations to seek further medical care in another facility or with another medical provider.

I, the patient, parent (or legal guardian) understand that regardless of the recommendations or outcome of the electronic consultation, this is a medical service for which I, the patient, parent (or legal guardian) agree and authorize the medical provider and Bodhi Medical Care, LLC a payment for such

rendered services. I, the patient, parent (or legal guardian) agree and understands that Bodhi Medical Care, LLC will submit a medical claim-invoice to my / my child's health plan and I agree and understand that such services may or may not be covered by health insurance and/or copayments or medical deductible can apply for such rendered services. I, the patient, parent (or legal guardian) agree and understand that if such service is not covered by my, my child's, parents' (or legal's guardian's) health plan, the fees associated with such e-consultation are generally $50 for each 15 (fifteen) minute time interval spent by the provider during the service of electronic consultation whether initial or in follow up and I authorize payment for such fees. I, the patient, parent (or legal guardian) understand that the electronic consultation may require and include more than one electronic exchange and may occur over period of time, and may include additional follow up.

I, the patient, parent (or legal guardian) understand, agree that such electronic consultation can occur only by sharing protected health information over electronic media and I, the patient, parent, (or legal guardian) authorize sharing of protected health information over electronic media, including as deemed necessary sharing of the medical record(s) in an electronic format. This electronic format may include email, fax or phone and internet. I, the patient, parent (or legal guardian) agree and understand that I select the option of the consultation such as email versus phone and I, the patient, parent (or legal guardian) understand that Bodhi Medical Care, LLC will make all possible efforts to provide and share such medical information over selected electronic media of my choice in compliance with the practice and general rules of exchange of protected health information over selected electronic media, however, I, the patient, parent (or legal guardian) agree understand to be solely responsible for the selected electronic media, its security or release of protected health information which is received to my choice of the electronic media. I, the patient, parent (or legal guardian) understand and agree that I am solely responsible for my selection of the electronic device such as phone, computer, ipad, fax or other electronic device, including the selection of hardware, software, firewall, encryption, service provider or other electronic equipment features I select to use myself in requesting or communicating the protected health information from my side. I, the patient, parent (or legal guardian) am solely responsible for security of such selected equipment I use and indemnify and hold harmless Bodhi Medical Care, LLC and its agents and representatives of any loss, theft or exposure of protected health information from my electronic device whether intentional or not.

I, hereby state that I am the responsible party for my or my child's medical care as well as for the payments for my / my child's medical care.

I agree to complete this electronic consultation request form, receive an e-consultation with its risks, benefits, including no service and an option to consider direct medical visit. I agree with payment authorization for such services and hereby submit my authorization to disclose protected health information/medical records over electronic media.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION/MEDICAL RECORDS

I hereby Authorize Apple Pediatrics-Bodhi Medical Care, LLC and their providers to release Protected Health Information pertaining to me or my child related to this electronic consultation.
I further authorize disclosure of the following protected health information:
Prior medical records available to Apple Pediatrics- Bodhi Medical Care, LLC.

I understand that:
1. Medical advice, recommendation and payment will not be conditional on whether I provide Authorization for any requested disclosure by Apple Pediatrics – Bodhi Medical Care, LLC. 2. I may inspect or receive a copy of the Protected Health Information described by this Authorization upon payment of a reasonable fee based on the policies and set fees of Apple Pediatrics-Bodhi Medical Care and as applicable by New York State Public Health Law. The fees for review and provision of medical advice include also value of medical provider's time to review, respond and if necessary research relavant information pertinent to the sought medical consultation. These fees are based on policies of Apple Pediatrics which are subject to change and are in addition to the fees set for release of any medical record or protected health information. 3. This Authorization is voluntary and that I have the right to refuse to sign it. 4. I may revoke this Authorization at any time by providing a written notice of revocation as specified by the Notice of Privacy. However such revocation would not affect any action taken by Apple Pediatrics-Bodhi Medical Care in reliance on this Authorization before receipt of my written revocation. 5. The information disclosed pursuant to this Authorization, except information protected by Federal and/or State regulations about confidentiality of drug and alcohol abuse records, HIV and Mental Health, may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state or federal laws. 6. My medical records may contain genetic testing information including test results. 7. This authorization is also applicable to patients with drug or alcohol related diagnoses, protected by Title 42 of the Code of Federal Regulations. 8. I hereby provide a medical records release authorization for the selected portion of the medical record and/or of protected health information related to any form, such as school form, as indicated by my selection. I hereby request to receive this document in an electronic format –of my choice. Such as unencrypted PDF, encrypted- password protected – PDF file and/or to have an option to transmit it by fax, mailed to me or I can pick it up in person as indicated by my selection. I agree to receive this protected health information through electronic means including, but not limited to the requested documents. I understand that once transmitted, I am solely responsible for safety, storage and further use of the received Protected Health Information. I understand that Bodhi Medical Care, LLC and its employees are not responsible, in any manner, for the unauthorized access of protected health information while same is being transmitted to me and are not responsible for safeguarding such information once same is delivered to me or to the party I designate as on my fax request. I understand that not all electronic communications referred to throughout the Electronic Communication Consent are encrypted and there is a risk and it is possible that the information contained therein could be read and/or intercepted by a third party.
I Hereby release the provider of said records from any legal responsibility or liability in connection with the release of the records indicated herein. This consent is subject to revocation at any time except to

the extent that the person who is to make the disclosure has already taken action in reliance on it. This Authorization will expire 1 year after being signed or sooner if requested by an authorized party. You may request change in expiration in writing by submitting your request to : yourdoctor@mybodhi.com and / or Bodhi Medical Care, LLC , 330 West 58th Street, Suite 414, NY, NY 10019.
Note to recipient of information: This information has been disclosed to you from records protected by New York State Law. New York State Law prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains.

PAYMENT AUTHORIZATION

I, the patient, parent (or legal guardian) agree to pay the applicable fee for the requested electronic consultation including protected health information and authorize the release of such information as per the full authorization above. I hereby provide credit card authorization of the credit card, which I already provided to Bodhi Medical Care, LLC including signed credit card authorization, to pay for the services I requested and selected, which are pertinent to the medical electronic consultation and/or other Protected Health Information. I hereby understand that the fees for such services as electronic consultation by providers of Bodhi Medical Care, LLC may not covered at all or may be only partially covered by the health insurance (with applied copayments or deductibles) and I am solely responsible for such payment authorization. Such payments may include fees for providing service of electronic consultation, review of information by provider, medical advice and/or records preparation and release or any non-covered medical services provided to me or my child / children rendered by Apple Pediatrics / Bodhi Medical Care, LLC to my dependent(s) as per the initial consent signed by myself or either of the parents/responsible party pertinent to treatments and responsibilities at the onset of care at Apple Pediatrics-Bodhi Medical Care, LLC. I understand that the fees for review of medical consultation including response include also value of medical provider's time to review, complete such medical consultation. These fees are based on policies of Apple Pediatrics which are subject to change and are in addition to the fees set for release of any medical record or protected health information. The fees associated with such e-consultation are generally $50 for each 15 (fifteen) minute time interval spent by the provider during the service of electronic consultation and I authorize payment for such fees. Thus I hereby consent in writing to authorize payments for services provided to me and my child / children such as access and review of submitted consultation by medical provider, as well as response which may include additional research and time for the relevant information sought.

Authorization: I, am a patient, parent and/or a legal guardian of my child, and I agree to pay for services rendered by you, Apple Pediatrics – Bodhi Medical Care, LLC, and authorize you to charge my credit card for applicable fee as a part of the service(s) rendered to me or my child. I understand that my health plan may not cover this service(s) or may not cover them in full and I will be also be responsible for this fee (which may be charged immediately, You may keep my credit card information on file and I authorize you to charge my credit card for any of those amounts I am obligated to pay you for services rendered in the future.