Lina Echavarria, MD, LLC
1951 SW 172nd Ave, Suite 412, Miramar FL 33029
954-702-4232

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Please complete all sections of this HIPAA release form. If any sections are left blank, this form will be invalid and it will not be possible for your health information to be shared as requested.

Section I – Authorization

I,_____, give my permission for _____ to share the information listed in Section II of this document with the person(s) or organization(s) I have specified in Section IV of this document.

Section II - Health Information

I would like to give the above healthcare organization permission to:

☐ Disclose my complete health record including, but not limited to, diagnoses, lab test results, treatment, and billing records for all conditions.

Or

☐ Disclose my complete health record except for the following information:
- ☐ Mental health records
- ☐ Communicable diseases including, but not limited to, HIV and AIDS
- ☐ Disclose Alcohol/drug abuse treatment records
- ☐ Genetic information
- ☐ Other: _____

_____

_____

Form of Disclosure:

☐ Electronic copy or access via a web-based portal
☐ Hard copy

Section III – Reason for Disclosure

Please detail the reason(s) why information is being shared. If you are initiating the request for sharing information and do not wish to list the reasons for sharing, write 'at my request'.

_____

_____

_____

_____

This document will be retained by the providing organization for seven years.

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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Section IV – Who Can Receive My Health Information

I give authorization for the health information detailed in section II of this document to be shared with the following individual(s) or organization(s):

Name: _____

Organization: _____

Address: _____

I understand that the person(s)/organization(s)listed above may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.

Section V – Duration of Authorization

This authorization to share my health information is valid:

- ☐ From _____ to _____

Or

- ☐ All past, present, and future periods

Or

- ☐ The date of the signature in section VI until the following event: _____

_____

I understand that I am permitted to revoke this authorization to share my health data at any time and can do so by submitting a request in writing to:

Name: _____

Organization: _____

Address: _____

I understand that:

- In the event that my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data.
- I understand that I do not need to give any further permission for the information detailed in Section II to be shared with the person(s) or organization(s) listed in section IV.
- I understand that the failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

This document will be retained by the providing organization for seven years.

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AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Section VI – Signature

_____ _____
Print Patient Name Date

_____
Signature

If this form is being completed by a person with legal authority to act an individual's behalf, such as a parent or legal guardian of a minor or health care agent, please complete the following information:

Name of person completing this form: _____

Signature of person completing this form: _____

Describe below how this person has legal authority to sign this form: _____

_____

_____

This document will be retained by the providing organization for seven years.

Lina Echavarria, MD
Obstetrics and Gynecology

GENERAL CONSENT FOR COMPREHENSIVE EXAMINATIONS INVOLVING PELVIS AND/OR RECTUM

I understand the planned procedure and I consent to a medically indicated physical examination which may include, but may not be limited to the following:

( ) a female Gynecological Exam which may include a rectal exam and a pelvic exam

( ) An Ultrasound Exam which may include a probe placed in the vagina.

( ) A rectal exam only

( ) An Ultrasound Exam which may include a probe placed into the rectum.

( ) Other procedures as listed _____

( ) Examination of external genitalia_____

This examination will be performed by any provider from _____ LLC.

The consent will remain active until I withdraw my consent in writing.

Name of Patient

_____

Signature of Patient or Patient's Representative if under 18

Date _____

Lina Echavarria, MD
Obstetrics and Gynecology

Consent for the use of email

The physician cannot guarantee but will use reasonable means to maintain security and confidentiality of email information sent and received.
Patients/Parent's/Legal Guardians must acknowledge and consent to the following conditions:

a. Email is not appropriate for urgent or emergency situations. Provider cannot guarantee that any particular email and/or text will be read and responded to within any particular period of time.
b. Email should be concise. The patient/parent/legal guardian should call and/or schedule an appointment to discuss complex and/or sensitive situations.
c. All email will usually be printed and filed into the client's medical record. Texts may be printed and filed as well.
d. Provider will not forward patient's/parent's/legal guardian's identifiable emails without the patient's/parent's/legal guardian's written consent, except as authorized
by law.
e. Patients/parents/legal guardians should not use email for communication of sensitive medical information.
f. Provider is not liable for breaches of confidentiality caused by the patient or any third party.

Patient Acknowledgement and Agreement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email between the provider and me, and consent to the conditions and instructions outlined, as well as any other instructions that my physician may impose to communicate with me by email.

Patient's name: _____
Signature: _____ Date:_____
Parent/Legal Guardian name: _____
Parent/Legal Guardian signature: _____ Date: _____

Lina Echavarria, MD
Obstetrics and Gynecology

All fees are payable at the time services are rendered. We accept most major credit cards. Your medical insurance is a contract between you and your insurance carrier and the terms of the contract vary according to the terms of the policy. Final payment for all charges is the patient's responsibility and should it be necessary for this account to turn over to either an attorney or collection agency for collections, I understand that I will be liable for any charges incurred. Including attorney fees and court cost.

Todos los honorarios por servicio deben ser pagados al recibir el servicio. Aceptamos ciertas tarjetas de credito. Su Seguro medico es un contrato entre usted y su compania de Seguro. Pagos por nuestros servicios dependen de los terminus de su poliza. El pago final de todos los cargos es su responsabilidad. Si es necesario tomar accion legal para cobrar la deuda, usted es responsable de los cargos legales.

We have elected not to carry Medical Malpractice insurance or otherwise demonstrate financial responsibility However; we agree to satisfy any adverse judgements up to the minimum amounts pursuant to S. 458.320 (5) (g). Florida law imposes penalties against non-insured physicians who fail to satisfy adverse judgements arising from claims of medical malpractice. This notice is pursuant to Florida Law.

Hemos elegido no llevar Seguro de neglicencia medica o no demonstrar de otra manera responsabilidad financiera. Sin embargo, acordamos satisfacer cualquier juicio adverso hasta las cantidades minimas conforme a S. 458.320 (5) (g). Florida impone penas contra los medicos de los no-asegurados que no pueden satisfacer los juicios adversos que se presentan de demandas de la neglijencia medica. Este aviso esta conforme a la ley de la Florida.

Physicians Release and Assignment

I hereby authorize payment directly to the physician of all benefits applicable and otherwise payable to me from my insurance carrier, HMO or other third-party payor, for services rendered by the physician. I understand that I am financially responsible to the physician for any and all charges that the carrier declines to pay. I hereby authorize the release of my medical records as deemed necessary for payment of insurance benefits.

Por lo presente autorizo el pago directamente a el medico todos los beneficios derivados del Seguro que ampara al paciente y que normalmente yo tendria derecho de percibir. Con mi firma autorizo transferir documentos relacionados a mi tratamiento medico a mi compania de Seguro para procesar mi reclamacion. Yo entiendo que soy responsible por todos los cargos no cubiertos bajo mi Seguro medico.

_____	_____	_____
Patient Name/ Nombre del Paciente	Signature/ Firma	DOB/ Fecha De Nacimiento

_____	_____	_____
Staff Witness Name	Staff Witness Signature	Date

Lina Echavarria, MD
Obstetrics and Gynecology

Annual Pap Smear Acknowledgement

Name: _____

DOB : _____ Age: _____

Initial the following:

_____ I certify I am here for my Annual Routine Well Woman Exam.

_____ I certify am not having any problems or concerns.

_____ I understand that if I am having a problem visit my insurance may require a copayment & deductible charge before being seen at this office during an annual exam visit.

_____ I authorize _____ company to pay direct to Lina Echavarria MD LLC , all benefits due to me, if any, by reason of service described for in the policy contract with insurance company.

_____ I will pay Lina Echavarria MD LLC, for all such charges incurred of for all charges in excess of whatever sums may be paid by the insurance company above mentioned, but not to exceed the balance of the facility's regular charges for this visit.

_____	_____	_____
Patient Printed Name	Patient Signature	DOB
_____	_____	_____
Staff Printed Name	Staff Signature	Date

Lina Echavarria, MD
Obstetrics and Gynecology

AUTHORIZATION to DISCUSS PROTECTED HEALTH INFORMATION

I, _____ authorize Dr. Lina Echavarria and staff to release or discuss information related to my medical condition (including information related to my treatment plan, medication information and/or billing information) to the following names:

1. _____ Relationship: _____
2. _____ Relationship: _____
3. _____ Relationship: _____

PLEASE BE ADVISED THAT ANY PERSON NOT REFERRED TO ON THIS LIST WILL OT BE GIVEN ANY INFORMATIO RELATED TO YOUR CARE, INCLUDING BILLING INFORMATION. YOU MAY CHANGE, RESTRICT OR EXPAND THIS LISTING AT ANY TIME.

**YOU ARE NOT REQUIRED TO LIST ANY NAME IF YOU DO NOT WISH TO

PLEASE LIST PHONE NUMBER YOU AUTHORIZE OUR STAFF TO CONGTACT YOU IN REGARDS TO:

- RESULTS-LABS, ULTRASOUND, ETC… PH:_____
- REMINDER NOTICES 2ND PH: _____
- CHANGE ON SCHEDULED APPOINTMENTS

PHARMACY INFORMATION:

Name: _____

Address and Cross Street : _____

City: _____ State: _____

Phone: _____

Patient Name: _____ DOB:_____

Signature: _____ Date: _____

Lina Echavarria, MD
Obstetrics and Gynecology

FEES AND INSURANCE INFORMATION

All fees are payable at the time services are rendered. We accept most major credit cards. Your medical insurance is a contract between you and your insurance carrier and the terms of the contract vary according to the terms of the policy. Final payment for all charges is the patients responsibility and should it be necessary for this account to turn over to either an attorney or collection agency for collections, I understand that I will be liable for any charges incurred. Including attorney fees and court cost.

Todos los honorarios por servicio deben ser pagados al recibir el servicio. Aceptamos ciertas tarjetas de credito. Su Seguro medico es un contrato entre usted y su compania de Seguro. Pagos por nuestros servicios dependen de los terminus de su poliza. El pago final de todos los cargos es su responsabilidad. Si es necesario tomar accion legal para cobrar la deuda, usted es responsable de los cargos legales.

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Por lo presente autorizo el pago directamente a el medico todos los beneficios derivados del Seguro que ampara al paciente y que normalmente yo tendria derecho de percibir. Con mi firma autorizo transferir documentos relacionados a mi tratamiento medico a mi compania de Seguro para procesar mi reclamacion. Yo entiendo que soy responsible por todos los cargos no cubiertos bajo mi Seguro medico.

_____	_____	_____
Patient Name/ Nombre del Paciente	Signature/ Firma	DOB/ Fecha De Nacimiento
_____	_____	_____
Staff Witness Name	Staff Witness Signature	Date

Lina Echavarria, MD
Obstetrics and Gynecology

OFFICE PHILOSOPHY

We, at Dr. Lina Echavarria LLC, think it is very important to spend as much time necessary with each patient to fully address your medical problems. This enables us to explain our suggestions and recommendations in depth and answer any questions you may have during your office visit. Our staff schedules patients accordingly and we try to be as efficient as possible in order to expedite your entrance and departure from this office. Please be reassured that we value your time. However, given the unpredictable nature of our work and the OB/GYN specialty, it is not uncommon to have a prolonged waiting period. On many occasions, we are delayed for such matters as medical problems which require immediate attention, hospital calls, physician calls, and/or emergencies. These issues are unforeseen and need to be addressed appropriately. We do not leave this office until all our patients are seen and all their medical problems are addressed, regardless of the time necessary.

Our well-trained staff members will assist you with any difficulties that may arise before, during or after your visit.

Thank You,

Lina Echavarria, MD

I acknowledge and understand the above stated Office Philosophy.

Name: _____ D.O.B. _____

Signature: _____ Date: _____

Notice of Privacy Practices

LINA ECHAVARRIA MD LLC

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION: Described as follows are the ways we may use and disclose health information that identifies you (Health information). Except for the following purposes, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice.

Treatment:
We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Payment:
We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give your health plan information so that they will pay for your treatment.

Healthcare Operations:
We may use and disclose Health Information for health care operation purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the medical care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you and to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

Fundraising Activities. We may use or disclose your Protected Health Information, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications. (Optional) If you do not want to receive these materials, please submit a written request to the Privacy Officer.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Data Breach Notification Purposes. We may use your contact information to provide legally-required notices of unauthorized acquisition, access, or disclosure of your health information. We may send notice directly to you or provide notice to the sponsor of your plan through which you receive coverage.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement; banking or transportation of organs, eyes, or tissues to facilitate organ, eye or tissue donation; and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Access to electronic records. The Health Information Technology for Economic and Clinical Health Act. HITECH Act allows people to ask for *electronic* copies of their PHI contained in electronic health records or to request in writing or electronically that another person receive an electronic copy of these records. The final omnibus rules expand an individual's right to access electronic records or to direct that they be sent to another person to include not only electronic health records but also any records in one or more designated record sets. If the individual requests an electronic copy, it must be provided in the format requested or in a mutually agreed-upon format. Covered entities may charge individuals for the cost of any electronic media (such as a USB flash drive) used to provide a copy of the electronic PHI.

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing.

We are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Right to Request Confidential communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communication, you must make your request, in writing. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. All complaints must be made in writing.

You will not be penalized for filing a complaint.

1951 SW 172nd Ave. Suiute 412
Miramar, FL 33019

Office: 954-702-4232
Fax: 844-235-8407

Attn:Compliance contact

Please sign the accompanying "Acknowledgement" form

PATIENT INFORMATION FORM

Lina Echavarria, MD
Obstetrics and Gynecology

PRIMARY CARE PHYS: _____ PHONE: _____ FAX: _____

NAME: _____ SEX: M ☐ F ☐ EMAIL: _____

SOCIAL SECURITY #: _____ AGE: _____ BIRTHDATE: _____ MARTIAL STATUS: S ☐ M ☐ W ☐ D ☐

STREET ADDRESS: _____ APT: _____

CITY: _____ STATE: _____ ZIPCODE: _____

HOME PHONE: _____ CELL PHONE: _____ EMAIL: _____

DRIVERS LISCENSE #: _____ DRIVER LISCENSE STATE: _____

EMPLOYER/SCHOOL: _____ TITLE: _____ PHONE #: _____

STREET ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

SPOUSE: _____ AGE: _____ BIRTHDAY: _____

SPOUSE EMPLOYER: _____ TITLE: _____ PHONE #: _____

STREET ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PRIMARY LANGUAGE: _____ REFERED BY: _____

EMERGENCY CONTACT OTHER THAN SOMEONE LIVING WITH YOU

NAME: _____ PHONE: _____ RELATIONSHIP: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PRIMARY INSURANCE INFORMATION

INSURANCE CO: _____
ADDRESS: _____
CITY/STATE/ZIP: _____
PHONE#: _____
I.D. #: _____
GROUP NAME OR #: _____
INSURED'S FULL NAME _____
IS THIS AN EMPLOYER PLAN? _____
INSURED'S SOCIAL SEC #: _____
INSURED'S DOB: _____
RELATIONSHIP TO INSURED: _____

SECONDARY INSURANCE INFORMATION

INSURANCE CO: _____
ADDRESS: _____
CITY/STATE/ZIP: _____
PHONE#: _____
I.D. #: _____
GROUP NAME OR #: _____
INSURED'S FULL NAME _____
IS THIS AN EMPLOYER PLAN? _____
INSURED'S SOCIAL SEC #: _____
INSURED'S DOB: _____
RELATIONSHIP TO INSURED: _____

GUARANTEE OF PAYMENT:

I fully understand that I am fully responsible for payment to the Physician in this office for all medical services provided to me. I also understand that all bills are payable and balance due at the time services are provided when other arrangements have been made. I agree to pay all collections due including reasonable attorney fees and cost in the event it becomes necessary to file suit to effect payment. I authorize payments to be made directly by my doctor

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize the Physicans in this office to release any information required in the course of my examination or my treatment to my insurance company for the purpose of processing any insurance claim.

ASSIGNMENT OF INSURANCE CLAIMS:

If insurance claim are made by this office on my behalf, I hereby authorize direct payment of any benefits to the Physician in this office for medical or surgical treatment received by me. In this circumstance, I understand that I am financially responsible for any charges not covered by insurance. I permit a copy of the authorization to be used in the place of the original.

Signature: _____ Date: _____

CONSENT, PERMISSION AND RELEASE
FOR USE OF PHOTO, VIDEO AND/OR AUDIO

I hereby give consent and permission to LINA ECHAVARRIA, MD, LLC to record the appearance, physical likeness and/or voice on videotape, on film, or digital video disk, or other means, and/or take photographs of the appearance of (print name) _____, age (if minor) _____.

Notwithstanding any prohibition as may be contained in Section 540.08, Florida Statutes, I hereby freely and voluntarily consent to the use and publication of my name, participation, picture, and/or likeness by LINA ECHAVARRIA, MD, LLC and/or its employees and/or agents, as well as the entity seeking this consent, and photographs, video and/or audio for any and all purposes including, but not limited to, educational, promotional, advertising, and trade, through any medium or format, including, but not limited to, film, photograph, digital, internet, telemedicine or exhibition, at any time from this date forward until I revoke this consent in writing.

I acknowledge that LINA ECHAVARRIA, MD, LLC is the sole owner of all rights in, and to, this visual and/or sound production and/or photograph(s) and the recordings, thereof, and that it has the right to use or reproduce the resulting images and/or sound as often as it finds necessary. I acknowledge that the photographs, video and/or audio may be used indefinitely by newsletters, brochures, Internet, intranet, or in other media once released.

LINA ECHAVARRIA, MD, LLC has the right, among other things, to edit and/or otherwise alter the visual or sound recording, or photographs, as needed. I understand I will receive no compensation for the appearance of the above-named person or for participation in said productions. I agree to hold LINA ECHAVARRIA, MD, LLC its employees and other parties harmless against claim, liability, loss, or damage caused by, or arising from, my participation in this production.

I have read this Consent before signing and fully understand the contents, meaning and impact of this consent. I understand that I am free to address any specific questions and have done so prior to signing this Consent.

Name: _____

Address: _____

Telephone: _____ Email address: _____

Signature: _____ Date: _____

Name of Parent/Legal Custodian (under age 18): _____

Signature of Parent/Legal Custodian (under age 18): _____

Witness Name: _____

Witness Signature: _____ Date: _____

I am revoking this consent. I understand that every effort will be made to remove the item from the site within a reasonable timeframe. I also understand that this file may have been copied without permission, and I agree not to hold LINA ECHAVARRIA, MD, LLC responsible for instances of these violations.

Signature: _____ Date: _____

Lina Echavarria, MD. LLC
Telehealth Informed Consent

Telehealth involves the use of secure electronic communications, information technology, or other means to enable a healthcare provider at one location, and a patient in another location to share individual patient clinical information for the purpose of consulting with, diagnosing, treating, prescribing, and/or referring the patient to in-person care, as determined clinically appropriate. This "**Telehealth Informed Consent**" informs the patient ("**patient,**" "**you,**" or "**your**") concerning the treatment methods, risks, and limitations of using a telehealth platform.

Services Provided:

Telehealth services offered by Lina Echavarria. MD, LLC ("**Practice**"), and the Practice's engaged providers (our "**Providers**" or your "**Provider**") may include a patient consultation, diagnosis, treatment recommendation, prescription, and/or a referral to in-person care, as determined clinically appropriate (the "**Services**"). Your Provider will be licensed in the state where you are located at the time of your consultation, or otherwise meet a professional licensure exception under applicable state law.

Electronic Transmissions:

The types of electronic transmissions that may occur using the telehealth platform include, but are not limited to:

- Appointment scheduling;
- Completion of medical intake forms;
- Exchange and review of patient medical intake forms, patient health records, images, diagnostic and/or lab test results via asynchronous communications;
- Two-way interactive audio in combination with store-and-forward communications between you and your Provider;
- Two-way interactive audio-video interaction between you and your Provider;
- Review and treatment recommendations by your Provider based upon output data from medical devices and sound and video files;
- Delivery of a consultation report; and/or
- Other electronic transmissions for the purpose of rendering clinical care to you.

Expected Benefits:

- Improved access to care by enabling you to remain in your preferred location while your Provider consults with you. Our telehealth services are available [3] hours a day, [3] days a week.
- Easy access for follow-up care. If you need to receive non-emergent follow-up care related to your treatment, please contact your Provider by email @ info@echavarriaobgyn.com or by phone 954-702-4232.

Service Limitations:

- The primary difference between telehealth and direct in-person service delivery is the inability to have direct, physical contact with the patient. Accordingly, some clinical needs may not be appropriate for a telehealth visit and your Provider will make that determination.
- OUR PROVIDERS DO NOT ADDRESS MEDICAL EMERGENCIES. IF YOU BELIEVE YOU ARE EXPERIENCING A MEDICAL EMERGENCY, YOU SHOULD DIAL 9-1-1 AND/OR GO TO THE NEAREST EMERGENCY ROOM. PLEASE DO NOT ATTEMPT TO CONTACT LINA ECHAVARRIA MD, LLC OR YOUR PROVIDER. AFTER RECEIVING EMERGENCY HEALTHCARE TREATMENT, YOU SHOULD VISIT YOUR LOCAL PRIMARY CARE DOCTOR.
- If it is determined during the initial screening of the telehealth visit that you should be seen in person, either in your Provider's office or in a recommended facility, you will not be charged for the telehealth visit. Appropriate emergency questions will be asked at the beginning of the telehealth visit that will determine what will be the best place for you to receive care.

Security Measures:

The electronic communication systems we use will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption. All the Services delivered to the patient through telehealth will be delivered over a secure connection that complies with the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Lina Echavarria, MD. LLC
Telehealth Informed Consent

Possible Risks:

- Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment and technologies, or provider availability.
- In the event of an inability to communicate as a result of a technological or equipment failure, please contact the Practice at 954-702-4232 and info@echavarriaobgyn.com.
- The quality of transmitted data may affect the quality of services provided by your Provider. Changes in the environment and test conditions could be impossible to make during delivery of telehealth services.
- In rare events, your Provider may determine that the transmitted information is of inadequate quality, thus necessitating a rescheduled telehealth consult or an in-person meeting with your local primary care doctor.
- In very rare events, security protocols could fail, causing a breach of privacy of personal medical information.
- In rare events, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other clinical judgment errors.

Patient Acknowledgments:

By checking the box associated with "Telehealth Informed Consent," you acknowledge that you understand and agree to the contents above and further agree with the following:

1. I understand that if I am experiencing a medical emergency, that I will be directed to dial 9-1-1 immediately and that our Providers are not able to connect me directly to any local emergency services.

2. I acknowledge that I have been given an opportunity to select a provider; Or, I have elected to consult with the next available provider. I acknowledge that prior to the consultation, I have been given the provider's credentials.

3. I understand there is a risk of technical failures during the telehealth encounter beyond the control of the Practice. I agree to hold harmless the Practice for delays in evaluation or for information lost due to such technical failures.

4. 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. I understand that I may suspend or terminate use of the telehealth services at any time for any reason or for no reason.

5. I understand that alternatives to telehealth consultation, such as in-person services are available to me, and in choosing to participate in a telehealth consultation, I understand that some parts of the Services involving tests (e.g., labs or bloodwork) may be conducted by individuals at my location, or at a testing facility, at the direction of our Providers.

6. 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.

7. I understand that it is necessary to provide a complete and accurate medical history and will update my medical health records periodically, but no less than once a year.

8. I understand persons may be present during the consultation other than my Provider in order to operate the telehealth technologies. I further understand that I will be informed of their presence in the consultation, and their role, and thus will have the right to request the following: (1) omit specific details of my medical history/examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telehealth examination; and/or (3) terminate the consultation at any time.

9. I understand I have the right to object to the videotaping of the telehealth consultation.

10. I understand there is no guarantee that I will be treated by our Providers. Our Providers reserve the right to deny care for potential misuse of the Services or for any other reason if, in the professional judgment of our Providers, the provision of the Service is not medically or ethically appropriate.

11. I understand that I will not be prescribed any narcotics for pain, nor is there any guarantee that I will be given a prescription at all.

12. I understand that federal and state law requires health care providers to protect the privacy and the security of health information. I understand that Practice will take steps to make sure my health information is not seen by anyone who should not see it. I understand that telehealth may involve electronic communication of my personal medical information to other health practitioners engaged by Practice who may be located in other areas, including out of state.

13. I understand that if I participate in a consultation, that I have the right to request a copy of my medical records and/or consultation report, which will be provided to me at reasonable cost of preparation, shipping and delivery.

14. I understand that I may be asked if I have a primary care doctor and, if so, whether I consent to sending a copy of my medical records and/or consultation report to my primary care doctor. Upon my consent, Practice will send copy of my medical records and/or consultation report to my primary care doctor, which will be billed to me at reasonable cost of preparation, shipping and delivery.

15. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes.

16. I understand that I may not be covered under my current health insurance plan for telehealth services.

Patient Informed Consent

I have carefully read this form and fully understand its contents, including the risks and benefits of the telehealth services. I hereby give my informed consent to participate in a telehealth consultation under the terms described herein. By checking the box associated with "Telehealth Informed Consent", I acknowledge that I understand and agree with the above and hereby consent to receive Practice's telehealth services:

☐ ACCEPT. By checking the Box for this "TELEHEALTH INFORMED CONSENT" I hereby state that I have read, understood, and agree to the terms of this document.

PATIENT'S NAME:
_____

PATIENT'S SIGNATURE:
_____

DATE:
_____

If signing on behalf of a minor:

PARENT/LEGAL GUARDIAN'S NAME:
_____

PARENT/LEGAL GUARDIAN'S SIGNATURE:
_____

DATE:
_____