20 Roche Brothers Way,
Unit 6-322
North Easton, MA 02301

Henry Lin, MD FACS
(774) 227-8482, ext 802
admin@healthierbodyinstitute.com

TELEHEALTH PATIENT CONSENT FORM

Bariatric Surgery Consultation & Treatment

PATIENT INFORMATION

Date: _____

Patient Name: _____

DATE OF BIRTH: _____Age: _____ Gender: _____

Contact Phone: _____

Email: _____

1. AGREEMENT TO TELEHEALTH SERVICES

☐ I hereby request and consent to receive telehealth services from **Healthier Body Institute** and its healthcare professionals for a bariatric surgery consultation and/or treatment.

☐ I understand that "telehealth" means the use of electronic communications, including two-way video conferencing, secure messaging, phone consultations, and other digital tools, to deliver healthcare services remotely. I understand that this may include:

- Video consultations (synchronous)
- Phone consultations
- Secure messaging and follow-up communications
- Review of my medical records and health information
- Prescription management via electronic systems
- Remote monitoring and assessment tools

2. VOLUNTARY NATURE OF CONSENT

☐ I understand that:

- My decision to use telehealth services is entirely voluntary
- I may refuse telehealth services and request in-person evaluation at any time
- Refusal to use telehealth will not impact my access to bariatric services or the quality of care I receive

If I withdraw consent, the provider will discuss alternative options with me

20 Roche Brothers Way,
Unit 6-322
North Easton, MA 02301

Henry Lin, MD FACS
(774) 227-8482, ext 802
admin@healthierbodyinstitute.com

3. SCOPE AND LIMITATIONS OF TELEHEALTH

☐ I acknowledge that:

- Telehealth is not appropriate for emergency medical conditions requiring immediate in-person evaluation or treatment.
- Physical examinations performed via telehealth (visual assessment, vital signs self-reporting, etc.) have limitations compared to traditional in-person exams.
- The healthcare provider may determine that in-person evaluation is necessary and may refer me for in-person care at any time.
- Telehealth is intended for consultation, evaluation, treatment planning, and follow-up care related to bariatric surgery consideration and management.
- Additional diagnostic procedures (laboratory work, imaging studies) may be required and may necessitate in-person visits.

☐ I understand these limitations and accept telehealth as an appropriate method of receiving bariatric care.

4. BARIATRIC-SPECIFIC RISKS AND BENEFITS

☐ I understand that:

Potential Benefits of Telehealth Bariatric Consultation:

- Increased accessibility and convenience
- Reduced travel time and costs
- Flexible scheduling options
- Continuity of care between in-person visits
- Easier documentation and record management

Potential Risks and Limitations:

- Limited physical examination capabilities (weight assessment, physical findings may be incomplete)
- Technical difficulties or interruptions in communication
- Inability to perform certain diagnostic procedures remotely
- Dependence on patient self-reporting of symptoms and measurements
- Privacy concerns if using unsecured personal devices or networks
- Potential delays in diagnosis or treatment if in-person assessment is needed
- The healthcare provider may not be able to fully evaluate surgical candidacy without in-person evaluation
- I understand that while research supports telemedicine for bariatric surgery preoperative evaluation, some components of my care may require in-person visits.

20 Roche Brothers Way,
Unit 6-322
North Easton, MA 02301

Henry Lin, MD FACS
(774) 227-8482, ext 802
admin@healthierbodyinstitute.com

5. CLINICAL RESPONSIBILITY & LIMITATIONS

☐ I understand that:

- A telehealth-based consultation establishes a limited physician-patient relationship for the purpose of bariatric care discussion and evaluation
- The healthcare provider is not responsible for diagnosing or treating conditions unrelated to weight management or bariatric surgery
- The healthcare provider will not have access to my complete medical history unless I provide it or authorize release of records
- I am responsible for informing the provider of all medical conditions, medications, allergies, and relevant health information
- If new or concerning medical conditions are identified during telehealth consultation, I may be referred to my primary care physician or emergency services
- The provider may recommend in-person evaluation or surgical assessment before proceeding with bariatric surgery

6. REQUIRED IN-PERSON VISITS

☐ I understand that certain aspects of bariatric care require in-person evaluation, including but not limited to:

- Initial comprehensive physical examination
- Final pre-operative clearance and testing
- Surgical consultation with the bariatric surgeon
- Post-operative follow-up visits as clinically indicated
- Management of surgical complications

☐ I agree to participate in in-person visits as recommended by my bariatric care team.

7. PRESCRIPTION MEDICATIONS

☐ I consent to the provider:

- Prescribing medications related to weight management and bariatric care via telehealth
- Sending prescriptions electronically to my pharmacy of choice
- Monitoring medication effectiveness and side effects via follow-up telehealth visits
- Adjusting or discontinuing medications as clinically indicated
- I understand that controlled substances have additional legal restrictions and may require more frequent in-person evaluation.

8. PRIVACY, CONFIDENTIALITY, AND SECURITY

Your privacy is important to us, and we endeavor to protect your personal information. The electronic communication systems we use for virtual video visits, eVisits, and eConsults have industry standard network and software security protocols in place that are intended to protect the confidentiality of your personal health data.

20 Roche Brothers Way,
Unit 6-322
North Easton, MA 02301

Henry Lin, MD FACS
(774) 227-8482, ext 802
admin@healthierbodyinstitute.com

HEALTHIER BODY INSTITUTE DOES NOT CONTROL THE DEVICES OR COMPUTERS OR THE INTERNET OVER WHICH YOU MAY CHOOSE TO ENTER CONFIDENTIAL OR PERSONAL INFORMATION AND CANNOT, THEREFORE, PREVENT INTERCEPTIONS OR COMPROMISES TO YOUR INFORMATION WHILE IN TRANSIT TO HEALTHIE

HIPAA Compliance:

☐ I understand that all federal and state laws regarding patient privacy and confidentiality apply to telehealth communications. The provider is required to comply with the Health Insurance Portability and Accountability Act (HIPAA) and state privacy laws.

Secure Communication Platforms:

☐ The provider will use secure, HIPAA-compliant platforms for all electronic communications, including:
- Encrypted video conferencing
- Secure patient portal messaging
- Encrypted email (when appropriate)

☐ The provider will NOT use:
- Unencrypted email for sensitive health information
- Consumer messaging apps (text, WhatsApp, etc.) for clinical discussions
- Unsecured video platforms (Zoom, FaceTime, etc.) for medical consultations

Patient Responsibility:

☐ I understand that I am responsible for:
- Maintaining the privacy of my login credentials and account access
- Using secure, private networks and devices for telehealth sessions
- Securing my own electronic devices and internet connection
- Not sharing my telehealth links or access codes with others
- Participating in telehealth sessions from a private location to protect my privacy

9. RECORDING OF SESSIONS

Recording Policy:

☐ I consent to the provider recording this telehealth session for quality improvement, training, or clinical documentation purposes.

☐ I do NOT consent to recording of telehealth sessions.

☐ I understand that:
- All recordings will be kept confidential and secure
- Recordings will only be accessed by authorized healthcare personnel

20 Roche Brothers Way,
Unit 6-322
North Easton, MA 02301

Henry Lin, MD FACS
(774) 227-8482, ext 802
admin@healthierbodyinstitute.com

- Recordings will be retained as part of my medical record and subject to the same privacy protections
- I may revoke consent to recording at any time

10. STORAGE OF HEALTH INFORMATION

☐ I understand that:

- My medical records from telehealth visits will be stored in a secure, encrypted system
- My health information will be retained according to applicable state and federal laws (typically 3-7 years after last visit)
- I have the right to request copies of my medical records
- I have the right to request amendments or corrections to my medical records
- Telehealth records are treated with the same confidentiality standards as in-person records

11. TECHNICAL REQUIREMENTS & INTERRUPTIONS

☐ I understand that:

- I am responsible for maintaining adequate internet connectivity and a device suitable for video conferencing (computer, tablet, or smartphone)
- Technical difficulties may occur, including loss of video/audio connection
- If the connection is interrupted, the provider will attempt to reconnect; if unsuccessful, we will reschedule the appointment
- The provider is not responsible for technical failures on my end or internet service interruptions
- I should test my technology 15 minutes before my scheduled appointment
- I should have a backup phone number available in case of technical difficulties

12. EMERGENCY PROTOCOLS

☐ I understand that:

- Telehealth is NOT appropriate for medical emergencies
- If I experience a medical emergency (chest pain, difficulty breathing, severe injury, thoughts of self-harm, etc.), I should:
  - **Hang up immediately**
  - **Call 911 or go to the nearest emergency room**
  - **Contact emergency services in my area**
- I am responsible for knowing how to access emergency services in my location
- The provider is not monitored 24/7 and may not be available for urgent issues
- If I have an urgent but non-emergency concern, I should contact the clinic directly or use the after-hours nurse line if available

20 Roche Brothers Way,
Unit 6-322
North Easton, MA 02301

Henry Lin, MD FACS
(774) 227-8482, ext 802
admin@healthierbodyinstitute.com

13. INSURANCE & PAYMENT

☐ I understand that:

- I am responsible for verifying that my insurance plan covers telehealth services
- Telehealth services may be billed differently than in-person visits
- I am responsible for any co-pays, deductibles, or out-of-pocket costs
- Payment and insurance questions should be directed to the clinic's billing department
- If my insurance does not cover telehealth, I may be responsible for the full cost

14. PATIENT RIGHTS

☐ I understand that I have the right to:

- Access my medical records and request copies
- Request amendments or corrections to my medical records
- Receive an explanation of how my health information is being used
- File a complaint with the provider or the U.S. Department of Health & Human Services (HHS) Office for Civil Rights if I believe my privacy rights have been violated
- Withdraw consent to telehealth and request in-person care
- Ask questions about the telehealth process and my care at any time
- Refuse telehealth and request traditional in-person services

Complaint Information:
If you have concerns regarding the privacy practices of this provider, you may contact:

- The provider's Privacy Officer at: (774) 227-8482, ext. 802
- The HHS Office for Civil Rights: 1-800-368-1019 or https://www.hhs.gov/ocr/privacy/hipaa/

15. ACKNOWLEDGMENT OF UNDERSTANDING

By signing this form, I certify that:

☐ I have read this entire consent form (or had it read to me)

☐ I understand the benefits, risks, and limitations of telehealth

☐ I understand the bariatric-specific considerations of remote consultation

☐ I have had an opportunity to ask questions and all my questions have been answered

☐ I understand I may withdraw consent at any time

☐ I voluntarily agree to receive telehealth services for bariatric surgery consultation and treatment

☐ I agree to provide accurate health information and inform my healthcare provider of any

20 Roche Brothers Way,
Unit 6-322
North Easton, MA 02301

Henry Lin, MD FACS
(774) 227-8482, ext 802
admin@healthierbodyinstitute.com

changes

☐ I understand the privacy and confidentiality protections that apply to my care

☐ I do NOT require an in-person visit before beginning telehealth services for initial bariatric consultation.

Patient Signature: _____ Date: _____

Printed Patient Name:_____

If patient is a minor or unable to sign:

Legal Guardian Signature: _____ *Date:* _____

Printed Guardian Name: _____ *Relationship to Patient:* _____

Witness Signature (if required): _____ Date: _____

Provider/Clinic Section:

Healthcare Provider Name:_____

Provider Signature: _____—--------_ Date: _____

Provider Title: _____ License Number: _____

Clinic Name: _____

PATIENT COPY

A copy of this signed consent form will be:

☐ Provided to the patient immediately (printed or electronic)
☐ Placed in the patient's medical record
☐ Available for patient request at any time

Patient Preferred Method of Receiving Copy:

☐ Printed copy given in person
☐ Emailed to: _____
☐ Available via secure patient portal