

## Telehealth Terms

DrLullaby, LLC  
9701 NE 2nd Avenue, #1208  
Miami Shore, FL 33138  
844-475-3379  
[Support@drlullaby.com](mailto:Support@drlullaby.com)

Thank you for choosing DrLullaby! We are committed to providing you with quality health care. Your clear understanding of our Telehealth Terms are important to our professional relationship. Please understand that consent for services is a part of that relationship. Please contact us if you have any questions about the terms of our services.

### Informed Consent for Psychotherapy

**General Information:** The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with us.

**Trainee Observers:** DrLullaby offers training opportunities to support our mission of improving access to Behavioral Sleep Medicine services. As part of this relationship, your treatment might include a trainee observer, or a trainee working under the supervision of a trained provider. By signing this consent, you are agreeing to treatment knowing that a trainee might be involved in your treatment

**The Therapeutic Process:** You have taken a very positive step by deciding to seek support for your sleep. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, challenge you to change behaviors, and bring up feelings of discomfort. Becoming aware of feelings and thoughts related to sleep problems can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. We cannot promise that your behavior or circumstance will change. We can promise to support you and do our very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself.

**Confidentiality:** The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of or exceptions to client held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to commit suicide or otherwise conducts himself/herself/themselves in a manner in which there is a substantial risk of incurring serious bodily harm.
  2. If a client threatens grave bodily harm or death to another person.
  3. If the provider has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.
  4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
  5. Suspected neglect of the parties named in items #3 and # 4.
  6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
  7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.
8. Communication with our office may be done through email, phone call, and text messaging. You can let our office know if you prefer to opt out of any form of communication.

**Professional Consultation:** Occasionally we may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

If we see each other accidentally outside of the therapy office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak briefly with you, but feel it appropriate not to engage in any lengthy discussions in public or outside of the therapy office.

**Respect for our Team:** We ask for your agreement to treat our providers, clinical staff and technology support with respect and courtesy. We will not accept cursing and hostility towards our team members. Our providers have the right to terminate their relationship with patients if and when they feel that their own stability is at risk by the manner in which a patient is communicating and interacting. Our team is always doing their best to provide you with support and care in a respectful fashion, and we ask that you do the same.

### **Consent For Use Of Telehealth Services**

1. I understand that my health care provider wishes me to engage in a telehealth services.
2. I understand that video conferencing technology will be used and will not be the same as in-person services due to the fact that I will not be in the same room as my provider.
3. I understand that a telehealth service has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.

4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

5. I understand that I can ask my provider questions in regard to this procedure.

### **Consent To Use Telehealth by “Healthie” [DrLullaby’s Electronic Health Record System]**

Telehealth by “Healthie” is the technology service we will use to conduct telehealth videoconferencing appointments. It is simple to use and there are no passwords required to log in.

By signing this document, I acknowledge:

1. Telehealth by “Healthie” is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
2. Though my provider and I may be in direct, virtual contact through the Telehealth Service, neither “Healthie” nor the Telehealth Service provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
3. The Telehealth by “Healthie” Service facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.
4. I do not assume that my provider has access to any or all of the technical information in the Telehealth by “Healthie” Service – or that such information is current, accurate or up-to-date. I will not rely on my health care provider to have any of this information in the Telehealth by “Healthie” Service.
5. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

For those patients that have a legal guardian, and/or parent (ie., under the age of 18 years), you are required to bring the legal guardian, and/or parent to your visit.

### **Appointment Cancellation Policy**

Missed appointments or appointments canceled less than 24 hours are subject to a \$60 fee. If you cancel 3 times in a row, no show 2 times in a row, or no show 3 times in total, your provider has the right to terminate the relationship. Our providers have limited time and slots available, and we must make these slots available to those ready to commit and keep their appointments as scheduled.

## **HIPAA Notice of Privacy Policy**

DrLullaby LLC (“DrLullaby,” “we,” “us,” or “our”) is committed to protecting and respecting your privacy. This HIPAA Notice of Privacy (“Notice”) describes how DrLullaby and other covered entities that interact with the System may use, store, and disclose your protected health information (“PHI”). This Notice also describes how you can get access to this information. Capitalized terms used but not defined herein have the meanings set forth in our Terms and Conditions of Use. Note that this Notice only applies to DrLullaby’s treatment of your PHI. The Telehealth Providers with whom you interact through the System may have their own policies and it is solely your responsibility to understand them. We will have no liability to you in respect thereof. This Notice relates solely to PHI transmitted through the Telehealth Service. For information regarding our treatment of all other information about you provided as part of your participation in the Telehealth Service or any other part of the System, please see our Privacy Policy. We understand that your health information is personal and we are committed to protecting it. We are required by law to maintain the privacy of your PHI and to give you this Notice of our legal duties and privacy practices concerning your PHI. We are also required by law to report to you any security breach involving your unsecured PHI. We must follow the terms of the current Notice.

### ***\*\* Uses and Disclosures of PHI That Do Not Require Your Authorization \*\****

**1. For Treatment.** Telehealth Providers may use your PHI to diagnose and treat mental health and insomnia related disorders, as well as provide behavioral health treatments consistent with evidence-based standards. DrLullaby may disclose your PHI to Telehealth Providers or to other healthcare providers who are involved in your healthcare or treatment, subject to obtain appropriate consents.

**2. For Payment.** DrLullaby may use and disclose your PHI so that we and other covered entities or healthcare providers can bill and collect payment from you, your insurance company, or a third party. This may include conducting insurance eligibility checks, determining enrollment status, and providing PHI to entities that help us submit bills and collect amounts owed.

**3. For Healthcare Operations.** Telehealth Providers may use and disclose your PHI for their healthcare operations and the healthcare operations of other covered entities with which you have or had a relationship. Healthcare operations may include activities necessary to provide healthcare services and ensure you receive quality customer service.

**4. To Communicate with You about Health-Related Products and Services.** DrLullaby may use or disclose your PHI to communicate with you regarding your care and related matters. For example, we may use or disclose your PHI to provide appointment reminders or inform you about alternative treatments or care settings.

**5. To Individuals Involved in Your Care or Payment for Your Care.** DrLullaby may disclose your PHI to a family member, other relative, friend, or other individual identified by you, who is

involved in your clinical care or payment for your care, provided you agree to this disclosure, you had an opportunity to object and did not do so, or we infer from the circumstances in our professional judgment that the disclosure is appropriate.

**6. As Required by Law.** We will disclose your PHI when required to do so by federal, state, or local law.

**7. To Avert a Serious Threat to Health or Safety.** We may use or disclose your PHI when necessary to prevent or lessen a serious threat to any person or the public.

**8. For Health Oversight Activities.** We may disclose PHI to a health oversight agency for activities authorized by law such as audits, inspections, and licensure or other activities necessary for oversight of the healthcare system, benefits programs, and civil rights.

**9. For Public Health and Safety.** We may disclose your PHI to government authorities for public health and safety activities such as preventing or controlling disease, injuries, or disabilities, reporting abuse, neglect, or domestic violence, and reporting recalls or adverse reactions to medications.

**10. For Lawsuits and Disputes.** We may disclose your PHI in response to a court or administrative order, or in response to a subpoena, discovery request, or other lawful process if efforts have been made to tell you about the request or to obtain a protective order.

**11. Law Enforcement.** We may disclose PHI to a law enforcement official for certain law enforcement purposes, such as reporting crime on our premises or responding to legitimate law enforcement inquiries.

**12. For Personal Representatives.** We may disclose your PHI to a legally authorized person to act on your behalf, such as a parent, legal guardian, or administrator or executor of your estate.

### ***Uses and Disclosures of PHI That Require Your Authorization***

**1. Sale of PHI.** We will not use or disclose your PHI in exchange for direct or indirect remuneration unless you authorize us to do so, or as permitted by HIPAA. We may exchange information when the information is deidentified in accordance with the HIPAA expert determination method and/or the HIPAA safe harbor method.

**2. Psychotherapy Notes.** Except in limited circumstances, we may not use or disclose notes recorded by a mental health professional documenting your conversation during a counseling session without your authorization.

**3. Marketing.** With your authorization, we may use or disclose your PHI for marketing purposes.

**4. Research Purposes.** We may use your de-identified data, in aggregate form, for research purposes. You may cancel your authorization in writing at any time, which will stop further use or disclosure for purposes covered by your authorization, except when we have already acted on your permission. We must also follow any law that is stricter than HIPAA.

***You Have the Following Rights with Respect to Your PHI:***

**1. You may** request restrictions on the use or disclosure of your PHI for treatment, payment or healthcare operations, or our disclosure of your PHI to someone involved in your care or payment for your care, like a family member or friend. We are not required to agree. If we agree, we will comply with your request except in certain emergency situations or as required by law.

**2. You may** request restrictions on certain disclosure of your PHI to your health plan for purposes of carrying out payment or healthcare operations regarding services paid for in full (out of pocket).

**3. You may** inspect and receive a paper or electronic copy of your medical records, if readily producible. Usually, this includes prescription and billing records. We may charge you for reasonable costs of responding to your request. We may deny your request, in which case you may request a review of the denial.

**4. You may** request we amend certain PHI if it is incorrect or incomplete. You must provide a reason to support your request. We may deny your request if the PHI is accurate and complete or is not part of the PHI kept by or for the relevant provider. If we deny your request, you have the right to submit a statement of disagreement. Your request will become part of your medical record, to be included when we make a disclosure of the item or statement you believe to be incomplete or incorrect.

**5. You may** request an accounting of disclosures of your PHI. This is a list of disclosures made of your PHI, other than for treatment, payment or healthcare operations, and other exceptions allowed by law. Your request must specify a time period, which may not be longer than six years from the date of the request.

**6. You may** request we contact you in a certain way or at a certain location. For example, you may request we contact you only at work or at a different residence or post office box. Your written request must state how or where you wish to be contacted. We will grant reasonable requests. If you would like to exercise any of these rights, contact DrLullaby at [support@drlullaby.com](mailto:support@drlullaby.com) to get the appropriate form, or submit a written request to DrLullaby LLC, 9701 NE 2<sup>nd</sup> Avenue, #1208, Miami Shores, FL 33138.

**Changes to This Notice of Privacy Practices**

We reserve the right to change this Notice and to make the revised Notice effective for PHI we already maintain or receive in the future. We will post a copy of the current Notice in a portion of the System accessible to you through your account, and it will take effect from the date posted whether or not you read it.

For More Information or to Report a Problem If you have questions about this Notice, contact DrLullaby LLC, 9701 NE 2<sup>nd</sup> Avenue, #1208, Miami Shores, FL 33138 or email support@drlullaby.com, **Attention: Dr. Jessica Hames, HIPAA Compliance Officer.**

If you believe your privacy rights have been violated, you may file a written complaint, and there will be no retaliation with our HIPAA Compliance Officer at the above address, or with the Secretary of the Dept. of Health and Human Services, Office for Civil Rights. You may file a complaint with the Secretary of the Dept. of Health and Human Services, Office for Civil Rights via:

- The Online Complaint Portal at <https://ocrportal.hhs.gov/>
- Postal mail or email by opening and completing the Civil Rights Discrimination Complaint Form Package at <https://www.hhs.gov/sites/default/files/ocr-cr-complaint-form-package.pdf>. You will need Adobe Reader software to fill out the complaint and consent forms. Mail the completed complaint and consent forms to:

**Centralized Case Management Operations  
U.S. Department of Health and Human Services  
200 Independence Avenue, S.W.  
Room 509F HHH Bldg.  
Washington, D.C. 20201**

**Or Email the completed forms to [OCRComplaint@hhs.gov](mailto:OCRComplaint@hhs.gov) (Please note that communication by unencrypted email presents a risk that personally identifiable information contained in such an email, may be intercepted by unauthorized third parties).**

**File a Complaint without the Civil Rights Discrimination Complaint Form Package**

If you prefer, you may submit a written complaint in your own format by either:

- **Mailing to**  
**Centralized Case Management Operations**  
**U.S. Department of Health and Human Services**  
**200 Independence Avenue, S.W.**  
**Room 509F HHH Bldg.**  
**Washington, D.C. 20201**
- **Emailing to [OCRComplaint@hhs.gov](mailto:OCRComplaint@hhs.gov)**

Be sure to include:

- **Your name**

- Full address
- Telephone numbers (include area code)
- E-mail address (if available)
- Name, full address and telephone number of the person, agency or organization you believe discriminated against you
- A brief description of what happened, including how, why, and when you believe your (or someone else's) civil rights were violated
- Any other relevant information
- Your signature and date of complaint
- The name of the person on whose behalf you are filing if you are filing a complaint for someone else

You may also include:

- Any special accommodation for us to communicate with you about this complaint
- Contact information for someone who can help us reach you if we cannot reach you directly
- If you have filed your complaint somewhere else and where you've filed

***You do not need to sign the complaint and consent forms when you submit them by email because submission by email represents your signature.***

Language assistance services for OCR matters are available and provided free of charge. OCR services are accessible to persons with disabilities.