EXHIBIT B
TELEHEALTH AGREEMENT

Introduction of Telehealth

Mindful Therapy Group Providers (“Provider(s)”) have the capability to provide sessions virtually via an online telehealth platform. “Telehealth” includes the practice of health care delivery, diagnosis, and treatment consultation using interactive video, audio, and/or data communications. For Telehealth sessions, you will be connecting with your Provider using an online encrypted platform that is HIPAA compliant.

Technology Requirements

You will need access to and familiarity with the appropriate technology to participate in the telehealth sessions.

Exchange of Information

Any paperwork exchanged will likely be provided through electronic means or through postal delivery.

During your Telehealth session, details of your medical history and personal health information will be discussed with you using interactive video or audio.

Your Provider may share your medical history and personal health information with other health professionals for treatment purposes, either in-person, via secure email or via interactive video or audio.

Payments

We require a credit card on file prior to any telehealth sessions. We will charge your credit card based on an estimate of the cost of services provided to us by your insurance company. We reserve the right to update the amount being charged as we receive updated information from your insurance company.

Local Practitioners

If a need for in-person mental health services arises, you may request to see your Provider in-person. If in-person sessions with your Provider are unavailable or infeasible, it is your responsibility to contact practitioners in your area. You may also contact your primary care physician if your Provider is unavailable.

Risks of Technology

Telehealth services rely on the use of technology. There are risks in transmitting information that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties.

Modification Plan

You and your Provider will regularly reassess the appropriateness of continuing to deliver services to you using these technologies and modify treatment plans as needed.

Emergency Protocol and Disruption of Service

During a Telehealth session, if you encounter a technological failure the most reliable backup plan is to contact your Provider directly. In case of Internet or platform failure, please use the Provider’s backup contact information. Your Provider may request that this contact information is only used during your scheduled visit for the purpose of working through technical difficulties.

In the event of disruption of service, or for routine or administrative reasons, it may be necessary to communicate by other means. In these circumstances, you may call the Mindful Therapy Group administrative offices at 425-640-7009 if you are unable to reach your Provider’s back-up contact number. If you are experiencing an emergency at the time of technical difficulty, please call 9-1-1 (for all emergencies) or 9-8-8 (for suicide crisis or mental health-related distress).

Confidentiality

It is your responsibility to maintain privacy on the client end of communication. If you elect to participate in Telehealth services, it is your responsibility to choose a secure location to interact with technology-assisted media and to be aware that family, friends, employers, co-workers, strangers, and hackers could either overhear your communications or have access to the technology that you are interacting with. Additionally, you agree not to record any Telehealth sessions.

The Laws & Professional Standards

The laws and professional standards that apply to your Provider's in-person mental health services also apply to Telehealth services. This document does not replace other agreements, contracts or documentation of informed consent.

TELEHEALTH ACKNOWLEDGEMENT

- I agree to participate in technology-based sessions and other healthcare-related information exchanges with my Provider. This means that I authorize information related to my health to be electronically transmitted in the form of images and data through an interactive video connection to and from my Provider and other persons involved in my health care.
- I represent that I am using my own equipment to communicate and not equipment owned by another and am specifically not using my employer's computer or network. I am aware that any information I enter into an employer's computer can be considered by the courts to belong to my employer and my privacy may thus be compromised.
- I have read this document carefully and fully understand the benefits and risks. I have had the opportunity to ask any questions I have and have received satisfactory answers. With this knowledge, I voluntarily consent to participate in Telehealth sessions, including, but not limited to, care, treatment, and services deemed necessary and advisable, under the terms described herein.

Patient Name: ____________________________

Patient Age and Date of Birth: ____________________________

*If patient is under the age of 18, please see the **State Law Addenda** for directions regarding who must sign this telehealth agreement.

Signature by or on behalf of Patient: ____________________________

If the Person Signing is not the Patient, Authority/Relationship with Patient: _________________________

RELEASE OF LIABILITY

I acknowledge that I have read this paragraph and specifically acknowledge that I understand its import. I unconditionally release, hold harmless, indemnify and discharge Mindful Therapy Group and Mindful Support Services, and their affiliates, contractors and employees, from any and all liability having its source in, arising from, or in connection with my participation in Telehealth. This includes, but is not limited to, any data breach caused by my or my provider's failure to either secure the technology devices or to ensure that the session

environments were secured. It is also my responsibility to ensure that the communications cannot be overheard.

Patient Name: ___________________________

Patient Age and Date of Birth: ___________________________

*If patient is under the age of 18, the patient's parent or other legal guardian must sign below.

Signature by or on behalf of Patient: ___________________________

If the Person Signing is not the Patient, Authority/Relationship with Patient: ________________________