PARAGON
COUNSELING GROUP

Context of Examination:
This is an examination undertaken for Logistic Health, Inc, a contractor with the Veteran's Administration (VA), specifically for the purpose of a Compensation and Pension (C&P) evaluation. The VA has provided LHI with information pertaining to your claim, and in turn, LHI has provided this information to this office including your electronic VA claims file . This is not a psychotherapeutic process, but instead, a consultative examination only; no treatment is being rendered. LHI/VA has referred you to this office for the purpose of C&P examination with either a licensed psychologist or psychiatrist. Note that your examiner does not make the C&P determination, but instead, provides information to LHI and the VA to assist them in their decision making with regard to your claim.

Your appointment today will be conducted via a teleheath system. Please note that by digitally signing this form, you agree to the following terms and conditions for your telehealth appointment with your examiner:

1. I understand that this appointment will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.
2. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telehealth appointment if it is felt that the videoconferencing connections are not adequate for the situation. I understand that I can discontinue the telehealth appointment at any time.
3. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the appointment other than my healthcare provider and specialty health care provider in order to operate the equipment. The above mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence during the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telehealth examination room; and/or (3) terminate the telehealth appointment at any time.
4. In an emergency situation, I understand that the responsibility of the telehealth specialist or provider may be to direct me to emergency medical services, such as emergency room. Or the telehealth provider may discuss with and advise my local provider. The telehealth specialist's or provider's responsibility will end upon the termination of the telehealth connection.
5. I have read this document carefully, and understand the risks and benefits of the telehealth appointment and have had my questions regarding the procedure explained and I hereby consent to participate in a telehealth appointment visit under the terms described herein.

Client or Guardian Signature:_____ Date:_____

I, _____, acknowledge receiving a complete copy of the 'Notice of Privacy Practices' from this office on this _____ day of _____, 20___.

Signature:_____

Witness:_____ Date:_____

Rights

*You are entitled to receive information about the methods of examination, the techniques used, and the duration of the procedures if known.
*Please contact the VA if you wish to obtain a second opinion with respect to the disability determination.
*You may terminate the examination at any time, but you should understand the completion of this examination will likely be necessary with regard to the determination of benefits.
*You should understand that the information developed in this examination, it it's entirety, will be shared with LHI/VA, by way of written report, verbal discussion/ consultation and records review. There are other exceptions to confidentiality, these exception are governed by state and federal law. If a legal exception arises during the evaluation, this will be discussed if feasible. For example, you should understand that information pertaining to life threatening emergencies and known or suspected child and/or adult abuse/neglect which may arise during examination cannot be held confidential; such information will be reported to the proper authorities or support/intervention systems. Certain court orders may require the release of information pertaining to this examination.

*Your examiner cannot be held responsible for the subsequent release of information once this examination is complete and the report is sent on to LHI/VA.

I hereby give my informed consent to this evaluation. I attest that I have received a copy of this document and have been informed verbally and in writing.

X Client Name (please print): _____ Date of Birth: _____/____/_____

Signature:_____

Witness:_____ Date:_____

Personal Health Information Release Form (HIPAA Release Form) **Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)**