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[Mind Milk MD

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TELEHEALTH REGULATORY INTAKE & DISCLOSURE PACKAGE

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This document contains critical federal and state-mandated disclosures.
Please read completely, fill out all sections, and sign the acknowledgement.

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PART 1: INFORMED CONSENT FOR TELEHEALTH SERVICES
(Compliant with HHS & State Medicaid Infrastructure Manuals)

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1. PURPOSE & NATURE OF SERVICES

Telehealth involves the delivery of healthcare services using electronic communications, information technology, or other means between a healthcare provider and a patient who are not in the same physical location. The technologies used may include secure interactive audio, video, data communications, and store-and-forward images.

2. EXPECTED BENEFITS

* Improved access to medical care by enabling a patient to remain at their home.
* More efficient medical evaluation, management, and triage.
* Access to specialized expertise that may be distant from the patient's area.

3. ANTICIPATED RISKS & TECHNICAL LIMITATIONS

While telehealth is highly effective, there are inherent risks that include, but are not limited to:

* Information transmitted may not be sufficient (e.g., poor resolution of images) to allow for appropriate medical decision-making by the provider.
* Delays in medical evaluation and treatment could occur due to deficiencies or failures of the communication equipment.
* Security protocols could fail, causing a breach of privacy of personal medical information.
* A lack of access to complete physical examination records may, in rare cases, result in adverse drug interactions, allergic reactions, or misdiagnosis.

4. MEDICAID & HHS PATIENT RIGHTS ATTESTATION

By signing this form, I understand and agree to the following conditions:

* RIGHT TO WITHDRAW CONSENT: I have the right to withhold or withdraw consent to telehealth services at any time during my care without affecting my right to future care or treatment, and without risking the loss or withdrawal of any Medicaid or health program benefits to which I am entitled.
* ALTERNATIVE CARE OPTIONS: I understand that if I do not wish to receive telehealth services, my provider will assist me in identifying alternative in-person care options within a reasonable geographic distance.
* CONFIDENTIALITY LAWS: The laws that protect the confidentiality of my medical information also apply to telehealth. No images or recordings of my specific telehealth sessions will be made or shared without my separate, explicit written consent.
* DISCLOSURE OF PERSONNEL: I have the right to be informed of all personnel present on the telecom stream at the remote site during my evaluation.

* EMERGENCY PROTOCOLS: I understand that telehealth is NOT an emergency intervention. If I experience a medical or psychological emergency, I agree to immediately call 911 or proceed to the nearest emergency room.

PART 2: NOTICE OF PRIVACY PRACTICES (NPP) SUMMARY
(In Accordance with 45 CFR § 164.520 & Updated Federal Privacy Frameworks)

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.

OUR LEGAL DUTY
We are required by federal and state law (including the HIPAA Privacy Rule) to maintain the privacy of your Protected Health Information (PHI). We must provide you with this notice detailing our legal duties and privacy practices.

HOW WE MAY USE AND DISCLOSE YOUR PHI
* FOR TREATMENT: We may disclose your PHI to doctors, nurses, technicians, or other personnel who are involved in taking care of your health via the telehealth infrastructure.
* FOR PAYMENT: We may use and disclose your PHI so that the telehealth services you receive can be billed and payment collected from you, an insurance company, or Medicaid.
* HEALTHCARE OPERATIONS: We may use PHI to run our practice, improve the quality of care, and conduct clinical auditing.
* REQUIRED BY LAW: We will disclose PHI when required by federal, state, or local law enforcement or regulatory authorities.

YOUR WRITTEN AUTHORIZATION REQUIRED FOR OTHER USES
Any uses or disclosures of your PHI for marketing purposes, sale of information, or disclosure of psychotherapy/substance use notes require your explicit, standalone written authorization, separate from this intake packet.

YOUR INDIVIDUAL HEALTH INFORMATION RIGHTS
* You have the right to inspect and copy your electronic medical record.
* You have the right to request a restriction on certain uses and disclosures.
* You have the right to request that we communicate with you via confidential alternative methods (e.g., specific secure messaging lines).
* You have the right to receive a paper or electronic copy of this complete Notice upon request.

PART 3: VANITY WEBSITE DATA & OUTBOUND COMMUNICATION DISCLOSURE
(CRITICAL NOTICE REGARDING NON-EHR PLATFORMS)

PLEASE NOTE: This website ([https://www.mindmilkmd.com,
https://www.coxandcoxllc.com]) is a public informational
and marketing platform ("Vanity Website"). It is completely distinct and
separated from our secure, encrypted Electronic Health Record (EHR) and
Telemedicine Clinical Platform.

1. DATA CAPTURE ON THIS WEBSITE
Any data you enter on this public-facing site (via generic "Contact Us" forms,
appointment requests, or standard unencrypted document download links) is
subject to consumer data privacy rules. While we use administrative safeguards
to download your form submissions safely, this vanity site should NOT be used
to transmit urgent clinical updates, active medical crises, or unsolicited
diagnostic imagery.

2. DUTY-TO-WARN: UNENCRYPTED EMAIL COMMUNICATIONS
If you elect to receive general emails, educational newsletters, or reminders
from this website system directly to your personal email account:
* Standard internet email is NOT completely secure or encrypted end-to-end.
* There is an inherent risk that unauthorized third parties could intercept
  unencrypted emails.
* By opting in below, you acknowledge this risk and grant us permission to
  transmit organizational or appointment information to your unsecured address.

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PART 4: PATIENT ACKNOWLEDGEMENT, OPT-INS, AND SIGNATURE BLOCK
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[ ] REQUIRED - INFORMED CONSENT & PRIVACY NOTICE:
    I acknowledge that I have read, understood, and agree to the Informed
    Consent for Telehealth Services (Part 1) and have had access to the full
    Notice of Privacy Practices (Part 2).

[ ] OPTIONAL MARKETING & NEWSLETTER OPT-IN (CAN-SPAM/HIPAA COMPLIANT):
    I authorize [Milk Mind MD/ Cox & Cox, LLC] to send educational medical newsletters,
    telehealth updates, and wellness offers to the email address provided below.
    I understand that my email identity constitutes protected data and that

I can revoke this opt-in at any time via a one-click unsubscribe link.

[ ] OPTIONAL TEXT MESSAGE (SMS) OPT-IN (TCPA COMPLIANT):
I consent to receive automated text reminders for upcoming telehealth appointments at the mobile number provided below. Message/data rates may apply.

Patient Full Legal Name (Print): _____

Patient Date of Birth: _____ Medicaid ID # (If Applicable): _____

Patient Email Address: _____

Patient Mobile Phone Number: _____

Signature of Patient or Authorized Legal Representative:

X_____ Date: _____

If Representative, State Relationship to Patient: _____

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[Clinic Administrative Section - For Internal Records Retention and Audit Only]
Received By: _____ Date Document Archived to EHR: _____