HIGHMARK WHOLECARE

WEBEX TELEVISIT CONSENT FORM

Member's Name: _____

Date of Birth: _____ Member ID# _____

I hereby consent to participate in a televisit using Cisco Webex ("Webex") with a Highmark Wholecare representative. I understand that this televisit will be similar to an in-person visit except that Webex's videoconference technology will allow me to communicate with the representative at a distance.

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

1. I understand that the federal and state laws that protect the privacy and confidentiality of my health information also apply to this televisit.

2. I understand that I may revoke/cancel my consent to participate in this televisit at any time, prior to or during the course of the televisit, without affecting my right to treatment, payment, enrollment, or eligibility for benefits.

3. I also understand that there are potential risks associated with participating in a televisit, including but not limited to interruptions due to technical difficulties and/or access by an unauthorized party despite best efforts to ensure security protocols.

4. I understand there is a risk of being overheard by anyone near me and that I am responsible for using a location that is private and free from distractions or intrusions.

5. I understand that the videoconference technology may allow for video or audio recordings and that neither I nor Highmark Wholecare may record the televisit.

My permission will be valid from the time I sign this form until (1) I am no longer enrolled with Highmark Wholecare, or (2) I send a written note to Highmark Wholecare stating that I am revoking/ cancelling my permission.

_____	_____	_____
Member Name Printed	Member Signature	Date

If the member is under the age of 18, the member's parent/guardian also must provide consent:

_____	_____	_____
Member's Parent/Guardian Name Printed	Member's Parent/Guardian Signature	Date

Highmark Wholecare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex gender, gender identity or expression, or sexual orientation.

We do not exclude people or treat them differently because of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex gender, gender identity or expression, or sexual orientation.

We provide free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

We provide free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact us at 1-800-392-1147

If you believe that Highmark Wholecare has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, creed, religious affiliation, ancestry, sex gender, gender identity or expression, or sexual orientation, you can file a complaint with:

Highmark Wholecare
Member Appeals
P.O. Box 22278
Pittsburgh, PA 15222
1-800-392-1147, [TTY/PA Relay 711],
Fax # (844)325-3435

The Bureau of Equal Opportunity,
Room 223, Health and Welfare Building,
P.O. Box 2675,
Harrisburg, PA 17105-2675,
Phone: (717) 787-1127, TTY/PA Relay 711,
Fax: (717) 772-4366, or
Email: RA-PWBEOAO@pa.gov

You can file a complaint in person or by mail, fax, or email. If you need help filing a complaint, Highmark Wholecare and the Bureau of Equal Opportunity are available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf , or by mail or phone at:

U.S. Department of Health and Human Services,
200 Independence Avenue SW.,
Room 509F, HHH Building,
Washington, DC 20201,
1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html