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Research Subject Informed Consent Form

Title of Study:	Facebook Ad Study s20-01796
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Emergency Contact:	Marie A. Bragg 347-377-0306

1. About volunteering for this research study

You are being invited to take part in a research study. Your participation is voluntary which means you can choose whether or not you want to take part in this study.

People who agree to take part in research studies are called “subjects” or “research subjects”. These words are used throughout this consent form. Before you can make your decision, you will need to know what the study is about, the possible risks and benefits of being in this study, and what you will have to do in this study. You may also decide to discuss this study and this form with your family, friends, or doctor. If you have any questions about the study or about this form, please ask us. If you decide to take part in this study, you must sign this form. We will give you a copy of this form signed by you for you to keep. When we say ‘you’, we are referring to you and/or your child.

Some of the people who may be able to take part in this study may not be able to give consent because they are under 18 years of age (a minor). Instead, we will ask their parent(s) or legal guardian to give consent. We will also ask the minor to agree (give their assent) to take part in the study. They will be given an Assent Form to sign. Throughout the consent form, “you” always refers to the “subject” or person who takes part in the study.

2. What is the purpose of this study?

For scientific reasons, this consent form does not include all of the information about the research question being tested. The researchers will give you more information when your participation in the study is over.

3. How long will I be in the study? How many other people will be in the study?

The study will last approximately 15 minutes. There will be a total of 480 participants.

4. What will I be asked to do in the study?

If you agree to be in this study, you will be asked to view a series of Facebook ads on a large computer and complete a brief survey that includes questions about yourself including, but not limited to, your level of education, race/ethnicity, age, and others.

Any identifiable *private information* collected and/or used for the purposes of this research will not be used or distributed for future research studies.

5. What are the possible risks or discomforts?

Risk of Study

One possible physical risk is experiencing boredom and irritation during the completion of the online survey. Another possible risk is a risk to your confidentiality. To make sure this does not happen, research records will be kept in a locked file; only the researchers will have access to the records.

Certificate of Confidentiality

This research is covered by a Certificate of Confidentiality from the National Institutes of Health. The researchers with this Certificate may not disclose or use information, documents, or biospecimens that may identify you in any federal, state, or local civil, criminal, administrative, legislative, or other action, suit, or proceeding, or be used as evidence, for example, if there is a court subpoena, unless you have consented for this use. Information, documents, or biospecimens protected by this Certificate cannot be disclosed to anyone else who is not connected with the research except, if there is a federal, state, or local law that requires disclosure (such as to report child abuse or communicable diseases but not for federal, state, or local civil, criminal, administrative, legislative, or other proceedings, see below); if you have consented to the disclosure, including for your medical treatment; or if it is used for other scientific research, as allowed by federal regulations protecting research subjects. The Certificate of Confidentiality will not be used to prevent disclosure as required by federal, state, or local law of child abuse or neglect, or harm to self or others.

The Certificate cannot be used to refuse a request for information from personnel of the United States federal or state government agency sponsoring the project that is needed for auditing or program evaluation by the National Institutes of Health Office of the Director which is funding this project or for information that must be disclosed in order to meet the requirements of the federal Food and Drug Administration (FDA). You should understand that a Certificate of Confidentiality does not prevent you from voluntarily releasing information about yourself or your involvement in this research. If you want your research information released to an insurer, medical care provider, or any other person not connected with the research, you must provide consent to allow the researchers to release it.

6. What if new information becomes available?

During the course of this study we may find more information that could be important to you. This includes information that might cause you to change your mind about being in the study. We will notify you as soon as possible if such information becomes available.

7. What are the possible benefits of the study?

You are not expected to get any benefit from being in this research study.

8. What other choices do I have if I do not participate?

Taking part in this study is completely voluntary. You may skip any questions that you do not want to answer. If you decide to not take part or to skip some of the questions, it will not affect your current or future relationship with NYU Langone Medical Center or the School of Medicine. If you decide to take part, you are free to withdraw at any time.

9. Will I be paid for being in this study?

You will be paid with a \$25 gift card at the end of the study for your participation. If you chose to leave or are withdrawn from the study for any reason before finishing the entire study, you will still be compensated.

As is required by the laws that apply to NYU Langone, in order for you to receive a payment (i.e. check, Clincard or bank gift card), you need to give the study staff either your Social Security number or your Alien

Registration number and will be asked to complete a IRS W9. If you do not have either of these numbers or are not willing to complete the IRS, you may be in the study but will not receive any payment.

10. Will I have to pay for anything?

There are no costs to you as a participant for your participation in this study.

11. What happens if I am injured from being in the study?

For medical emergencies contact 911. If you think you have been injured as a result of taking part in this research study, tell the principal investigator as soon as possible. The principal investigator's name and phone number are listed at the top of page 1 of this consentform.

We will offer you the care needed to treat injuries directly resulting from taking part in this research. We may bill your insurance company or other third parties, if appropriate, for the costs of the care you get for the injury, but you may also be responsible for some of them.

There are no plans for the NYU School of Medicine or Medical Center to pay you or give you other compensation for the injury. You do not give up your legal rights by signing this form.

12. When is the study over? Can I leave the Study before it ends?

If you decide to participate, you are free to leave the study at any time. Leaving the study will not interfere with your future care, payment for your health care or your eligibility for health care benefits.

13. How will you protect my confidentiality?

The medical information is protected health information, or "PHI", and is protected by federal and state laws, such as the Health Insurance Portability and Accountability Act, or HIPAA. This includes information in your research record as well as information in your medical record at NYU Langone Health. In compliance with NYU Langone Health policies and procedures and with HIPAA, only those individuals with a job purpose can access this information.

You have a right to access information in your research record. In some cases, when necessary to protect the integrity of the research, you will not be allowed to see or copy certain information relating to the study while the study is in progress, but you will have the right to see and copy the information once the study is over in accordance with NYU Langone Health policies and applicable law.

14. HIPAA Authorization

As noted in the Confidentiality section above, federal law requires us, and our affiliated researchers, health care providers, and physician network to protect the privacy of information that identifies you and relates to your past, present, and future physical and mental health conditions. We are asking for your permission (authorization) to use and share your health information with others in connection with this study- in other words, for purposes of this research, including conducting and overseeing the study.

Your treatment outside of this study, payment for your health care, and your health care benefits will not be affected even if you do not authorize the use and disclosure of your information for this study.

What information may be used or shared with others in connection with this study?

You have a right to access information in your medical record. In some cases when necessary to protect the integrity of the research, you will not be allowed to see or copy certain information relating to the study while the study is in progress, but you will have the right to see and copy the information once the study is

over in accordance with NYU Langone Medical Center policies and applicable law.

Who may use and share information in connection with this study?

The following individuals may use, share or receive your information for this research study:

- The Principal Investigator, study coordinators, other members of the research team, and personnel responsible for the support or oversight of the study. All of these individuals have been subject to a background check by NYU Langone Medical Center during their on-boarding as paid faculty, staff, and/or as unpaid volunteers.
- Governmental agencies responsible for research oversight (e.g., the Food and Drug Administration or FDA).

Your information may be re-disclosed or used for other purposes if the person who receives your information is not required by law to protect the privacy of the information.

What if I do not want to give permission to use and share my information for this study?

Signing this form is voluntary. You do not have to give us permission to use and share your information, but if you do not, you will not be able to participate in this study.

Can I change my mind and withdraw permission to use or share my information?

Yes, you may withdraw or take back your permission to use and share your health information at any time. If you withdraw your permission, we will not be able to take back information that has already been used or shared with others. To withdraw your permission, send a written notice to the principal investigator for the study noted at the top of page 1 of this form. If you withdraw your permission, you will not be able to stay in this study.

How long may my information be used or shared?

Your permission to use or share your personal health information for this study will never expire unless you withdraw it.

15. The Institutional Review Board (IRB) and how it protects you

The IRB reviews all human research studies – including this study. The IRB follows Federal Government rules and guidelines designed to protect the rights and welfare of the people taking part in the research studies. The IRB also reviews research to make sure the risks for all studies are as small as possible.

The NYU IRB Office number is (212) 263-4110. The NYU School of Medicine's IRB is made up of:

- Doctors, nurses, non-scientists, and people from the Community

16. Who can I call with questions, or if I'm concerned about my rights as a research subject?

If you have questions, concerns or complaints regarding your participation in this research study or if you have any questions about your rights as a research subject, you should speak with the Principal Investigator listed on top of the page 1 of this consent form. If a member of the research team cannot be reached or you want to talk to someone other than those working on the study, you may contact the Institutional Review Board (IRB) at (212) 263-4110.

When you sign this form, you are agreeing to take part in this research study as described to you. This means that you have read the consent form, your questions have been answered, and you have decided to volunteer.

Name of Subject (Print)

Signature of Subject

Date

Name of Person Obtaining Consent (Print)

Signature of Person Obtaining Consent

Date

Signature of Parent(s)/Guardian for Child

I give my consent for my child to take part in this research study and agree to allow his/her health information to be used and shared as described above.

Name of Parent (Print)

Signature of Parent

Date