

Agreement for Telemental Health Services

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As a client receiving behavioral services through telemental health technologies, I understand:

- Telemental health is the delivery of individual, couple, and family therapy using interactive technologies (use of audio, video or other electronic communications) between a practitioner and a client/patient who are not in the same physical location.
- The interactive technologies used in telemental health incorporate network and software security protocols to protect the confidentiality of client/patient information transmitted via any electronic channel. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption.

Software Security Protocols:

- Electronic systems used will incorporate network and software security protocols to protect the privacy and security of health information and imaging data, and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption.

Benefits & Limitations:

- This service is provided by technology (including but not limited to video, phone, text, apps and email) and may not involve direct face to face communication. There are benefits and limitations to this service.
- Regardless of the sophistication of today's technology, some information my practitioner would ordinarily get in in-person consultation may not be available in teleconsultation. I understand that such missing information could in some situations make it more difficult for my practitioner to understand my problems and to help me get better. My practitioner will be unable to physically touch me or to render any emergency assistance if I experience a crisis.

Technology Requirements:

- I will need access to, and familiarity with, the appropriate technology in order to participate in the service provided.
- The telemedicine software Zoom (zoom.us) will be utilized and can be readily used on a smart phone, tablet, or computer.
- I represent that I am using my own equipment to communicate and not equipment owned by another, and 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.

Exchange of Information:

- The exchange of information will not be direct and any paperwork exchanged will likely be provided through electronic means or through postal delivery.
- During my telemental health consultation, details of my medical history and personal health information may be discussed through the use of interactive video, audio, or other telecommunications technology.
- It may also mean that my private health information may be transmitted from my practitioner's mobile device to my own or from my device to that of my practitioner via an 'application' (abbreviated as "app").
- I understand that a variety of alternative methods of mental health care may be available to me, and that I may choose one or more of these at any time. Dr. Heiden-Rootes has explained the alternative to my satisfaction.

- I understand that I will be informed of the identities of all parties present during the consultation or who have access to my personal health information and of the purpose for such individuals to have such access.

Local Practitioners:

- If a need for direct, in-person services arises, it is my responsibility to contact Dr. Heiden-Rootes' office for an in-person appointment or my primary care physician if my behavioral practitioner is unavailable. I understand that an opening may not be immediately available in either office.

Contact Information:

- I have received a copy of my practitioner's contact information, including his or her name, telephone number, pager and/or voice mail number, business address, mailing address, and e-mail address (if applicable).
- I have also been provided with a list of local support services in case of an emergency. I am aware that my practitioner may contact the proper authorities and/or my designated, local contact person in case of an emergency.

Self-Termination:

- I may decline any telemental health services at any time without jeopardizing my access to future care, services, and benefits.
- I further understand that I do not have to answer any question that I feel is inappropriate or whose answer I do not wish persons present to hear; that any refusal to participate in the consultation(s) or use of technology will not affect my continued treatment and that no action will be taken against me.
- I acknowledge, however, that diagnosis depends on information, and treatment depends on diagnosis, so if I withhold information, I assume the risk that a diagnosis might not be made or might be made incorrectly.
- Were that to happen, my telehealth-based treatment might be less successful than it otherwise would be, or it could fail entirely.

Risks of Technology:

- These services rely on technology, which allows for greater convenience in service delivery. There are risks in transmitting information over technology that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties.
- I understand that telemental health is a new delivery method for professional services, in an area not yet fully validated by research, and may have potential risks, possibly including some that are not yet recognized.
- Among the risks that are presently recognized is the possibility that the technology will fail before or during the consultation, that the transmitted information in any form will be unclear or inadequate for proper use in the consultation(s), and that the information will be intercepted by an unauthorized person or persons.
- In rare instances, security protocols could fail, causing a breach of privacy of personal health information. I understand that a physical examination may be performed by individuals at my location at the request of the consulting practitioner.

Alternatives:

- The alternatives to the consultation(s) have been explained to me, including their risks and benefits, as well as the risks and benefits of doing without treatment. I understand that I can still pursue in-person consultations. I understand that the telemental health consultation(s) does not necessarily eliminate my need to see a specialist in person, and I have received no guarantee as to the telemental consultation's effectiveness.

Modification Plan:

- Dr. Heiden-Rootes and I will regularly reassess the appropriateness of continuing to deliver services to me through the use of the technologies we have agreed upon today, and modify our plan as needed.

Emergency Protocol:

- In emergencies, in the event of disruption of service, or for routine or administrative reasons, it may be necessary to communicate by other means:
 - Crisis hotlines are available 24/7 from Provident Crisis Hotline at **1-800-273-TALK (8255)** and LGBT National Hotline **1-888-843-4564**.

Disruption of Service:

- Should service be disrupted during a video session, Dr. Heiden-Rootes will call you via the preferring phone number provided to continue the session.
- For other communication, email and text communication is permitted.

Practitioner Communication:

- My practitioner will respond to communications and routine messages within 2 business days

Client Communication:

- It is my responsibility to maintain privacy on the client end of communication. Insurance companies, those authorized by the client, and those permitted by law may also have access to records or communications.

Type of Services:

- My health care practitioner has explained how the telemental health consultation(s) is performed and how it will be used for my treatment. My behavioral practitioner has also explained how the consultation(s) will differ from in-person services, including but not limited to emotional reactions that may be generated by the technology.
- In brief, I understand that my practitioner will not be physically in my presence. Instead, we will see and hear each other electronically, or that other information such as information I enter into an “app” will be transmitted electronically to and from myself and my practitioner.
- I am agreeing to participate in the following types of telemental health services with Dr. Heiden-Rootes, while acknowledging that the course of psychotherapy may change, and the participants may change, by agreement of all required parties. This means I authorize information related to my medical and behavioral health to be electronically transmitted in the form of images and data through an interactive video connection to and from the above-named practitioner.

_____ Individual Psychotherapy
_____ Couples Psychotherapy
_____ Family Psychotherapy

- I also agree that the following individuals will be part of the psychotherapy process and **we agree to be in the same physical place during video services and share one screen:**

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Psychotherapy Fees: (unless otherwise negotiated)

- Payment is accepted via Ivy Pay for collecting a credit card or through mailing in a check to Dr. Heiden-Rootes’ office address (listed above). By signing below you are agreeing to one of these modes of payment.

- 25-30 minute psychotherapy session fee: \$75; 55-60 minute psychotherapy session fee: \$175; 85-90 minute psychotherapy session fee: \$250

Storage:

- My communication exchanged with my practitioner will be stored in the following manner: All communication and documentation are saved on an encrypted server that is password protected.
- I understand that consultations, test results, and disclosures will be held in confidence subject to state and/or federal law.
- I understand that I am ordinarily guaranteed access to my records and that copies of records of consultation(s) are available to me on my written request.
- I also understand, however, that if my practitioner, in the exercise of professional judgment, concludes that providing my records to me could threaten the safety of a human being, myself or another person, he or she may rightfully decline to provide them. If such a request is made and honored, I understand that I retain sole responsibility for the confidentiality of the records released to me.

Laws & Standards:

- The laws and professional standards that apply to in-person behavioral services also apply to telehealth services. This document does not replace other agreements, contracts, or documentation of informed consent.

Confirmation of Agreement:

My signature on this AGREEMENT FOR TELEMENTAL HEALTH SERVICES means I have read this document carefully, understand the risks and benefits, and consent to everything above and indicates my consent to participate in telemental health services. I have had the opportunity to ask any questions and received satisfactory answers. With this knowledge, I voluntarily consent to participate in the telemental health services, including but not limited to any care, treatment, and services deemed necessary and advisable, under the terms described herein.

Client Signature: _____ Date: _____

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Provider Signature: _____ Date: _____