DIVERSE ASSESSMENTS & TREATMENT, LLC

TODD M. SIGLER, PSYD, LP, NCC

TELEHEALTH/TELEMENTAL HEALTH/TELEBEHAVIORAL HEALTH INFORMED CONSENT

INTRODUCTION OF TELEHEALTH/TELEMENTAL HEALTH/TELEBEHAVIORAL HEALTH

As a patient receiving behavioral services through Telebehavioral health technologies, I understand:

Telebehavioral health is the delivery of behavioral health services 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 telebehavioral health incorporate network and software security protocols to protect the confidentiality of 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.

TECHNOLOGY REQUIREMENTS

I will need access to, and familiarity with, the appropriate technology in order to participate in the service provided.

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.

SELF-TERMINATION

I may decline any telebehavioral health services at any time without jeopardizing my access to future care, services, and benefits.

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.

MODIFICATION PLAN

My practitioner and I will regularly reassess the appropriateness of continuing to deliver services through the use of the technologies, 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.

DISRUPTION OF SERVICE

My practitioner may utilize alternative means of communication.

PATIENT 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. I will take the following precautions to ensure that my communications are directed only to my psychologist or other designated individuals:

STORAGE

My communication exchanged with my practitioner will be stored in the following manner: The audio and video are destroyed by Doxy.me at the conclusion of the call.

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

_____	___/___/_____	_____	___/___/_____
Patient/Legal Representative	Date	Dr. Todd M. Sigler, PsyD, LP. NCC	Date

todd@DiverseAssessments.org
http://www.DiverseAssessments.org
(651) 481 – 0664 ext.)# Office
(612) 392 – 0400 Fax

Patient Printed Name: _____

ADDENDUM A

Name of Client/Patient: _____

ELECTRONIC TRANSMISSION OF INFORMATION

I, the undersigned, a citizen of Minnesota, or, my designee(s), on my behalf, agree to participate in technology-based consultation and other healthcare-related information exchanges with Dr. Todd M. Sigler, PsyD, LP, NCC, a licensed psychologist ("practitioner").

This means that 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, other persons involved in my health care, and the staff operating the consultation equipment.

MOBILE APPLICATION

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 behavioral health care may be available to me, and that I may choose one or more of these at any time. My behavioral health care provider has explained the alternative to my satisfaction.

EQUIPMENT

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.

IDENTIFICATION

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.

TELEBEHAVIORAL HEALTH PROCESS

Dr. Sigler has explained or provided written explanation of how the telebehavioral health consultation(s) is performed and how it will be used for my treatment. Dr. Sigler 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.

ELECTRONIC PRESENCE

In brief, I understand that Dr. Sigler 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.

LIMITATIONS

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.

RISKS

I understand that telebehavioral 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.

RELEASE OF INFORMATION

I authorize the release of any information pertaining to me determined by my practitioner, my other health care practitioners or by my insurance carrier to be relevant to the consultation(s) or processing of insurance claims, including but not limited to my name, Social Security number, birth date, diagnosis, treatment plan and other clinical or medical record information.

DISCONTINUING CARE

I understand that at any time, the consultation(s) can be discontinued either by me or by my designee or by my health care practitioners.

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.

LIMITS OF CONFIDENTIALITY

I also understand that, under the law, and regardless of what form of communication I use in working with Dr. Sigler, Dr. Sigler may be required to report to the authorities information suggesting that I have engaged in behaviors that endanger others.

ALTERNATIVES

The alternatives to the telehealth services 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 therapy sessions. I understand that the telebehavioral health consultation(s) does not necessarily eliminate my need to see a specialist in person, and I have received no guarantee as to the telebehavioral consultation's effectiveness.

RECORDS

I understand that my telebehavioral session audio and video will be destroyed at the conclusion of the telehealth session. I understand that therapy, 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 Dr. Sigler, 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 and that I may have to pay a reasonable fee to get a copy.

CONTACT INFORMATION

I have received a copy of Dr. Sigler's contact information, including his name, telephone number, voice mail number, business address, mailing address, and e-mail address.

EMERGENCY CARE

I acknowledge, however, that if I am facing or if I think I may be facing an emergency situation that could result in harm to me or to another person; I am not to seek a telebehavioral consultation. Instead, I agree to seek care immediately through my own local health care practitioner or at the nearest hospital emergency department or by calling 911.

FINAL AGREEMENT

I have read this document carefully and fully understand the benefits and risks. I have had the opportunity to ask any questions I have and have received satisfactory answers. With this knowledge, I voluntarily consent to participate in the telebehavioral consultation(s), including but not limited to any care, treatment, and services deemed necessary and advisable, under the terms described herein.

_____	___/___/_____	_____	___/___/_____
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