Tele-Visit Health Informed Consent

Introduction of Tele-Visit Health:

As a client or patient receiving behavioral services through Tele-Visit health technologies, I understand:

Tele-Visit 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 Tele-Visit 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.

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.

During my Tele-Visit health consultation, details of my medical history and personal health information may be discussed with myself or other behavioral health care professionals through the use of interactive video, audio or other telecommunications technology.

Local Practitioners:

If a need for direct, in-person services arises, it is my responsibility to contact my behavioral practitioner's office for an in-person. I understand that an opening may not be immediately available in the office.

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 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:

In emergency situations

- In live threatening situations, go to the ER of your choice
- For routine interruptions in communication, patient notes and messages can be sent through our secure portal.

Disruption of Service:

Should service be disrupted

- Please call our front office 803.216.0850 Therapist will do their best to contact patient to help facilitate reconnection.

For other communication

- Patient portal messaging or secure email

Practitioner Communication:

My practitioner may utilize alternative means of communication in the following circumstances:

Online testing/screening, telephone as needed, portal messaging, and secure email

My practitioner will respond to communications and routine messages
within 3 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.

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

Ensure private location and LOG OUT after visit

Use of headphones and microphone as needed

Storage:

My communication exchanged with my practitioner will be stored in the following manner:

- Visit notes scribed by the provider as they deem appropriate
- Sessions will not be recorded or stored

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:

_____

Client Printed Name

_____ _____

Signature of Client or Legal Guardian Date

_____

Printed Name of Practitioner

Addendum A

Name of Client/Patient: _____

Electronic Transmission of Information:

I, the undersigned, a citizen of _____, or _____, my designee(s), on my behalf, agree to participate in technology-based consultation and other healthcare-related information exchanges with_____, a behavioral health care practitioner ("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.

Tele-Visit Health Process:

My health care practitioner has explained how the Tele-Visit 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.

Electronic Presence:

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.

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 Tele-Visit 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.

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 Tele-Visit 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.

Release of Liability:

I unconditionally release and discharge Barnabas Behavioral Healthcare, LLC, its affiliates, agents, employees; and my practitioner and his or her designees from any liability in connection with my participation in the remote consultation(s).

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 Tele-Visit consultation(s), including but not limited to any care, treatment, and services deemed necessary and advisable, under the terms described herein.

_____	_____	_____
Name	Date	Witness

Consent to Treat a Minor:

The above release is given on behalf of_____ _____because the patient is a minor or has been determined to be incompetent to give medical consent for the following reasons:

_____

_____

_____

_____	_____	_____
Name	Date	Time