centerpoint counseling

# Telemental Health Informed Consent

**As a client receiving mental health services through Telemental health technologies, I understand: *Please initial in the blanks.***

_____ Telemental health is the delivery of mental 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. *I understand that I must be physically located in a state that my provider is licensed to provide services in at the time of my telemental health appointment. (Please check with the front office for licensed states 208-359-4840)

_____ The technologies used in Telemental health use 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: *Please initial in the blanks.***

_____ Electronic systems used will include 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: *Please initial in the blanks.***

_____ 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: *Please initial in the blanks.***

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

**Exchange of Information: *Please initial in the blanks.***

_____ 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 with myself or other behavioral health care professionals through the use of interactive video, audio or other telecommunications technology.

**Local Practitioners: *Please initial in the blanks.***

_____ If a need for direct, in-person services arises, it is my responsibility to schedule an appointment with practitioners in my immediate area, or to contact my behavioral practitioner's 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.

**Self-Termination: *Please initial in the blanks.***

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

**Risks of Technology: *Please initial in the blanks.***

_____ These services rely on technology, which allows for greater convenience in service delivery. However, I understand 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: *Please initial in the blanks.***

_____ 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: *Please initial in the blanks.***

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

- In emergencies
- In the event of disruption of service
- For routine or administrative reasons.

My practitioner will respond to communications and routine messages within: **48 hoursClient**

**Communication: *Please initial in the blanks.***

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

_____ I will take the following precautions to ensure that my communications are directed only to my therapist or representatives of Centerpoint Counseling Services.

- Contacting my practitioner using contact information provided me.Accessing scheduled sessions through the client portal on EHRYourway
- Contacting my practitioner by phone through Centerpoint Counseling main contact number.

**Storage: *Please initial in the blanks.***

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

- All written notes by my therapist documenting interaction will be stored in a secure web-based application called EHRYourway, powered by Adaptamed.
- Video communication will not be stored, unless otherwise stated.

**Laws & Standards: *Please initial in the blanks.***

_____ The laws and professional standards that apply to in-person mental health services also apply to telehealth services. This document does not replace other agreements, contracts, or documentation of informed consent (See intake paperwork).

**Confirmation of Agreement:** *Please enter name(s) and Elec Signatures.*

_____

Client Printed Name

_____

Signature of Client Date

_____

Legal Guardian Printed Name

_____

Legal Guardian Signature Date

# Addendum

Name of Client/Patient:_____

Electronic Transmission of Information:
I, the undersigned, 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") with Centerpoint Counseling Services.

This means that I authorize information related to my medical and mental 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.

**Telemental Health Process:** My health care practitioner has explained how the Telemental health session(s) is performed and how it will be used for my treatment. My behavioral practitioner has also explained how the sessions (s) will differ from in-person services, including but not limited to emotional reactions that may be generated by the technology.

**Additional Services:** I understand that it is my duty to inform my practitioner of electronic interactions regarding my care that I may have with other health care providers.

**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 session may not be available in virtual sessions. 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 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 session, that the transmitted information in any form will be unclear or inadequate for proper use in the session(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 session(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 session(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 session(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

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

**Alternatives:** The alternatives to the session(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 session(s) does not necessarily eliminate my need to see a specialist in person, and I have received no guarantee as to the Telemental session's effectiveness.

**Records:** I understand that my Telemental session(s) may be recorded and stored electronically as part of my medical records. 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 session(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 and that I may have to pay a reasonable fee to get a copy.

Additionally, I understand that my records may be used for telehealth program evaluation, education, and research and that I will not be personally identified if such a use occurs.

I hereby authorize these disclosures to take place without prior written consent.

**Compensation:** I understand that I am not entitled to royalties or to other forms of compensation for participation in any Telemental session(s) or other information exchange.

**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.

**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 Telemental session. 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.

These are the names and telephone numbers of my local emergency contacts (including local physician; crisis hotline; trusted family, friend, or adviser).

_____

Name Telephone Number

_____

Name Telephone Number

**Witness Consent to Treat a Minor**: The above release is given on behalf of: (Name of client)

_____

because the patient is a minor or has been determined to be incompetent to give medical consent for the following reasons:

_____

**Release of Liability):** I unconditionally release and discharge Centerpoint Counseling, its affiliates, agents, employees; its affiliates, agents, and employees; and my practitioner and his or her designees from any liability in connection with my participation in the remote session(s).

**Auto-payment Agreement/Credit Card Payment Authorization:**

I understand that Centerpoint Counseling Services requires notice of cancellations at least 24 hours in advance. Late cancellations and missed appointments will be charged to my credit card ½ the cost of my scheduled appointment on the date of the missed appointment. This includes sessions that don't take place or are interrupted due to technical difficulties.

_____ **I understand that my card will <u>automatically be charged</u> for Late cancellations and Missed appointments on the date of the appointment.**

Copayments, co-insurance, deductibles, and other anticipated patient responsibility payments are due at the time of service and will be charged to my credit card upon virtual check in. As a courtesy to me, Centerpoint Counseling will send a claim to my insurance for the remaining balance when I've given them my insurance information two business days prior to my appointment. They will give my insurance company 30 days to pay the claim. After 30 days, I agree to have them charge my card for the remaining balance.

_____ **I understand that <u>my card will automatically be charged</u> for copayments, co-insurance, deductibles, and other balances as they become due and without additional notice.**

Credit Card Information:

_____

Name on Card

_____ _____ / _____ _____

Card Number Exp Mo / Year 3-digit code

**Final Agreement:**

I have read this document carefully and fully understand the benefits and risks. I agree to the Auto-payment Agreement and authorize use of my credit card to process payments as they become due. 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 Telemental session(s), including but not limited to any care, treatment, and services deemed necessary and advisable, under the terms described herein. *Please enter name(s) and Elec Signatures.*

_____

Client Printed Name

_____

Signature of Client Date

_____

Legal Guardian Printed Name

_____

Legal Guardian Signature Date