TELEHEALTH INFORMED CONSENT

Name of Client: _____ Date: _____

As a client or patient receiving behavioral services through telehealth technologies, I understand:

Introduction of Telehealth:
Telehealth is the delivery of behavioral health services using interactive technologies (use of audio, video or other electronic communications) between a therapist and a client who are not in the same physical location. The interactive technologies used in telehealth 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.

Electronic Transmission of Information:

- I, the undersigned agree to participate in technology-based consultation and other healthcare-related information exchanges with _____, a therapist at Summit Psychological Services. This means that I authorize information related to my psychotherapy to be electronically transmitted in the form of images and data through an interactive video connection to and from the above-named therapist.

- It may also mean that my private health information may be transmitted from my therapist's mobile device or computer to my own or from my device to that of my therapist via an 'application" (abbreviated as "app").

- The alternatives to telehealth 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 any telehealth consultation(s) do not necessarily eliminate my need to see a specialist in person, and I have received no guarantee as to the therapist's effectiveness.

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

- 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.

Telehealth Process:
My therapist has explained how the telehealth consultation(s) is performed and how it will be used for my therapy. My therapist 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 therapist 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 therapist.

Modification Plan:
My therapist 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.

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

Limitations:
Regardless of the sophistication of today's technology, some information my therapist 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 therapist to understand my problems and to help me get better.

Risks:
I understand that telehealth 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. 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.

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.

Release of Information:
I authorize the release of any information pertaining to me determined by my therapist, my other health care therapists 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.

Limits of Confidentiality:
I also understand that, under the law, and regardless of what form of communication I use in working with my therapist, my therapist may be required to report to the authorities information suggesting that I have engaged or am intending to engage in behaviors that endanger either myself and/or others.

Client Communication:
I understand that it is my responsibility to maintain privacy on my end of communication. I will take the following precautions to ensure that my communications are directed only to my therapist or other designated individuals:

_____

Records:
I understand that my telehealth consultation(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 consultation(s) are available to me on my written request.

I also understand, however, that if my therapist, 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.

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

_____

Contact Information:
I have received a copy of my therapist'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 therapist may contact the proper authorities and/or my designated, local contact person in case of an emergency.

Need for Direct or In-Person Services:
If a need for direct, in-person services arises, it is my responsibility to contact SPS for an in-person appointment or my primary care physician if my therapist is unavailable. I understand that an opening may not be immediately available.

If I need direct contact with my therapist, I understand that:

- my therapist may utilize alternative means of communication in the following circumstances:

  _____

- my therapist will respond to communications and routine messages within:

  _____

Emergency Care:
I acknowledge 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 telehealth consultation. Instead, I agree to seek care immediately through my own local health care therapist or at the nearest hospital emergency department or by calling 911. 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_____
- Should service be disrupted_____
- For other communication_____

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

_____ Name _____ Telephone Number

Release of Liability:
I unconditionally release and discharge _____ (name of therapist), Summit Psychological Services and their employees from any liability in connection with my participation in the remote consultation(s).

Reimbursement for Telehealth Services by insurance and Medicare:

- I understand that the Financial Policy Information form also applies to the delivery of Telehealth services. In addition to the Financial Policy Information form, there are some extra considerations for clients who are using Telehealth Services.

- Since the use of Telehealth for psychotherapy is an emerging field, I understand that insurance companies vary in their responses to reimbursing Telehealth.

- I understand that I need to check with my insurance provider to ascertain if my carrier has a specific policy for reimbursing Telehealth services. I understand that I am financially responsible should it not be a covered service under my insurance policy. In the event that I do not have a provision for Telehealth services to be delivered by a therapist at SPS, I understand that I will need to discuss with my therapist whether I am willing or able to pay out-of-pocket for the telehealth session.

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.

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

Confirmation of Agreement:

_____Client Printed Name

_____ Signature of Client or Legal Guardian

_____ Date

_____ Printed Name of SPS Therapist

_____ Signature of Therapist

_____ Date

Consent to Treat a Minor:

The above release is given on behalf of _____because the client is a minor.

_____ Client Printed Name

_____ Signature of Client or Legal Guardian

_____ Date

_____ Signature of Therapist

_____ Date

This form has been adapted from the Telebehavioral Health Institute and personalized for the needs of Summit Psychological Services by A.Johnson 3.15.2020