Informed Consent for Telemental Health Services

Introduction of Telemental Health:

- As a client or patient receiving behavioral services through telemental health technologies, I understand:
- Telemental 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 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.
- As a consumer of telemental health services with Attachment and Experiential Therapy, LLC, I recognize that I must be within the state where my therapist is licensed during the time of service (NH or FL).

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 telemental health consultation, details of my medical history and personal health information may be discussed with myself or other behavioral health care professionals using interactive video, audio or another telecommunications technology.

Local Practitioners:

- If a need for direct, in-person services arises, it is my responsibility to contact practitioners in my area or my general physician if my behavioral practitioner is unavailable. I understand that an opening may not be immediately available in either office. In the case of an emergency, I

will call 911 or contact Riverbend Community Mental Health in Concord, NH or appropriate crisis center in your area of NH or FL or call the suicide hotline number at: 1-800-273-8255

Self-Termination:

- I may decline any telemental 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 to me using 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 _ 1-800-273-8255 or 911 or Riverbend Community Mental Health if in NH) or Capital Regional Medical Center in Tallahassee (if in FL) or appropriate crisis center that is local to your area in your state.

Disruption of Service:

- Should service be disrupted _____appointment will be rescheduled
- For other communication: phone contact at discretion of client_____

Practitioner Communication:

- My practitioner may utilize alternative means of communication in the following circumstances: __at discretion of client and in the event online communication was cut off_____
- My practitioner will respond to communications and routine messages within ____24-48 hours_____

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: o

  _____

Electronic Transmission of Information:

I, the undersigned, a resident of _____ (name of state) , 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. Telemental

Health Process:

- 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.

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 in 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 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. 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.
- 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.

Storage:

- My communication exchanged with my practitioner will be stored in the following manner: _____
  _____
- 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: Lori Olson, LCMHC (NH), LMHC (FL)