Telemental Health Informed Consent

As a client receiving behavioral services through telehealth methods, I understand:

Telemental health is the delivery of behavioral health services using interactive technologies (audio, video or other electronic communications) between a provider and a client that 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 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 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.

1. This service is provided by technology (included but not limited to video, phone, text and email) and may involve direct face to face communication. There are benefits and limitations to this service. I will need access to, and familiarity with, the appropriate technology in order to participate in the service provided. The exchange of information will not be direct and any paperwork exchanged will likely be provided through electronic means or through postal delivery. During your virtual care consultation, details of your medical history and personal health information may be discussed with you or your behavioral health care professionals through the use of interactive video, audio or other telecommunications technology.

2. If a need for direct, face to face services arises, it is my responsibility to contact practitioners in my area such as _____, _____, or _____ or to contact my behavioral health practitioner's office for a face to face appointment or my primary care provider if my behavioral health practitioner is unavailable. I understand that an opening may not be immediately available in either office.

3. I may decline any telehealth services at any time without jeopardizing my access to future care, services or benefits.

4. 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. 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.

5. In emergencies, in the event of disruption of services, or for routine or administrative reasons, it may be necessary to communicate by other means:

    a. In emergency situations: _____
    b. Service disruption: _____
    c. For other communication: _____

6. My practitioner may utilize alternative means of communication in the following circumstances: video connections fail or phone line access is disrupted.

7. My practitioner will respond to communications and routine messages within 48 hours on business days or on the next business day following weekends, holidays, or vacations.

8. 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.

9. I will take the following precautions to ensure that my communications are directed only to my behavioral health practitioner or other designated individuals: Double check email addresses; double check phone numbers; double check to whom email is sent (reply vs reply all).

10. My communication with my behavioral health practitioner will be stored in the following manner: In compliance with HIPAA regulations in secured file cabinets and/or secured electronic medical record files.

11. 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.

_____
Client Printed Name

_____ _____
Signature of Client or Legal Guardian Date

Omega J. Galliano, MFT, LADC, LP
Practitioner Printed Name

_____ _____
Signature of Practitioner Date

Addendum A

Client Name: _____

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

You understand that a variety of alternative methods of mental health care may be available to you, and that you may choose one or more of these at any time. Your mental health care provider has explained the alternative to your satisfaction.

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.

My health care practitioner has explained how the telehealth consultation(s) is performed and how it will be used for my treatment. My health care 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.

You understand that it is your duty to inform your physician of electronic interactions regarding your care that you may have with other health care providers.

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 my practitioner and I. 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.

I understand that telehealth consultation(s) are a new form of treatment, in an area not yet fully validated by research, and that they 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.

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 limited to my name, Social Security number, birth date, diagnosis, treatment plan and other clinical or medical record information.

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 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.

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.

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

I understand that my telehealth consultation(s) may be recorded and stored electronically as part of my medical records. The practitioner will inform me if this is to occur and the reasons for this being necessary. 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 medical records and that copies of records of consultation(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/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.

I understand that I am not entitled to royalties or to other forms of compensation for participation in any telehealth consultation(s) or information exchange.

I have received a copy of my practitioner's contact information, including his/her name, telephone number, business address, mailing address, and email 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.

I acknowledge, however, that 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 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 – Relationship –Telephone number

_____

Name – Relationship –Telephone number

_____

Name – Relationship –Telephone number

_____

Name – Relationship –Telephone number

_____

Name – Relationship –Telephone number

I unconditionally release and discharge Omega J. Galliano and Counseling Connections, its affiliates, agents and employees; and any other organization involved in the remote consultation(s) from any liability in connection with my participation with telehealth remote consultations.

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

_____	_____	_____
Name	Date	Witness

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

_____	_____	_____
Parent or Legal Guardian	Date	Time