Tele-behavioral Health Information and Consent to Treat

Please read carefully and check off all boxes before signing.
Please return before sessions begin.

Introduction of Tele-counseling or Tele-behavioral Health:

As a client of tele-counseling I understand:

- I understand that counseling is being delivered through interactive technologies between counselor and client and it is not the same as using in-person location
- I understand the technologies used in tele-counseling use software security protocols to protect the confidentiality of client information transmitted via any electronic channels. These protocols include measures to safeguard the data and to aid in protecting against intention and/or unintentional corruption.

Software Security:

- Electronic systems used will incorporate network and software security to protect the privacy of the client

Benefits and Limitation

- 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.
- My counselor has explained how tele-counseling is used and how it will be used for my treatment. My counselor has also explained how using this platform will differ from face-to- face services, including but not limited to emotional reactions that may be generated by the technology.
- Regardless of the today's technology, I understand that my counselor may not be able to receive all important information and that some information that my counselor might have received during in-person sessions may not be available making it more difficult to understand my problems which may make it more difficult to help me get better.
- I acknowledge that my diagnosis depends on information which I provide to my healthcare provider and that treatment depends on the information I provide. I realize that I assume a risk that a diagnosis may not be made correctly as a result of my withholding information and/or because of the limitations of tele-counseling.
- My counselor will not be able to touch me and may not be able to assist in any emergency or crisis that I may experience.

Technology Requirements:

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

- I understand that I shall use my equipment and my equipment only. I can not use any equipment that belongs to a family member, a friend or an employee or employer.
- I understand that if I do use any equipment that is not mine, or belongs to an employer the courts hold the information stored on that technology to belong to the owner of the equipment and my privacy may be compromised.

Identification:

- I understand that I will be informed of the identities of all parties present during the session or who have access to my personal health information and of the purpose for such individual to have such access.

Exchange of Information:

- The exchange of information will not be directed and any paperwork exchanged will likely be provided through electronic means or though postal delivery
- During my tele-counseling session, details of my medical and personal health history may be discussed with my counselor through the use of interactive video, audio, or other telecommunications technology.
- I understand that my private health information will be transmitted from my mobile device to that of my counselors.
- I understand that there is a variety of alternative methods of tele-behavioral heath care available to me and that I may choose one or more of these at any time.
- My counselor has explained each alternative method to my satisfaction.

Release of Information:

- I authorize the release of any information pertaining to me determined by my counselor to other healthcare providers and or my insurance provider to process insurance claims. This information may include but is not limited to my name, social security number, phone number, birthdate, diagnosis, treatment plan or any other information required.

Medical Information:

- I agree to provide information concerning any and all medications that I take for physical and mental health purposes. This list will include names and doses of all medications.

Local Practitioners:

- If there is a need for direct, in-person services, I recognize it is my responsibility to contact my tele-counselor. In addition, I recognize it is my responsibility to contact a provider in my area such as _____ or I may make an in-office appointment with my tele-counselor or primary care physician if my counselor is unavailable.
- I understand that an immediate open may not be available in either office.

- I understand that it is my duty to inform my counselor of any other electronic interactions I may have with another mental healthcare provider.

Self-Termination:

- I may decline any tele-counseling services at any time without jeopardizing my access to future care, services, and benefits.
- I understand I do not have to answer any question that I feel inappropriate.
- I understand that my refusal to use any technology will affect my continued treatment and that I have the right to choose whatever means of participating in my treatment.
- I assume the risk of a wrong diagnosis as a diagnosis might be compromised as a consequence of tele-counseling and the information that either I provide within the limits of the technology.
- I recognize that tele-health counseling might be less successful than if in-person and it may fail completely.

Risk of Technology:

- These services rely on technology, which allows for greater convenience in services. There are risks in transmitting information which include but are not limited to breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties

Modification Plan:

- My counselor and I will reassess the appropriateness of continued delivery of counseling through tele-services as agreed upon.

Storage and Records:

- I agree that my communication with my counselor will not be stored electronically.
- I do not agree with any video taping of the session.
- I understand that notes will be made by my counselor and will be held in a safe and confidential state.
- I agree to sign any release form needed for my counselor to contact any other practitioner, doctor, lawyer, psychiatrist, nurse practitioner, insurance company or any other entity that may request information.
- I understand that my counselor has the right to deny providing information to any entity which may be deemed unnecessary or harmful or unsafe to my mental health.

Limits of Confidentiality:

- I understand that under the law and regardless of what form of communication I use in working with my counselor, my counselor may be required to report to the authorities information suggesting that I have engaged in behaviors that have endangered myself or

others. I understand that by law, my counselor, must report and seek out help for issues around suicide, homicide, child abuse and elder abuse.

Client Communication:

- I will take the following precautions to ensure privacy while I am in session.
  1. I am in a secluded and private room with the door closed
  2. I have placed a note on the door saying "In session."
  3. I have shown, through sweeping my device around the room, that I am the only person in the room

Contact Information:

- I have received a copy of my counselor's contact information which includes name, telephone, pager, business address, mailing address, e-mail address, web address
- My counselor also has provided a list of local support services to me in case of an emergency.
- I am aware and have provided information of local emergency and authority contacts in case of an emergency. I have included both name and phone number.

Dr.:_____

Psychiatrist:_____

Local Hospital:_____

Local Chief of Police:_____

- I also agree to call 911 incase of an emergency to seek out immediate care.

Emergency Protocol:

- In emergencies, or if services are disrupted, or for routine or administrative reasons it may be necessary for communications by other means
- In case of an emergency please use the following phone number:_____
- My counselor may also contact me through the following:
  1. E-mail_____
  2. Text_____
  3. Home phone_____
  4. Address_____
     _____

Release of Liability:

- I unconditionally release and discharge Ruth Altamura-Roll, MA, NCC, LPC of any liability in connection with my participation in remote consultation.

Final Agreement:

- I have read this document carefully and fully understand the benefits and risks. I have had the opportunity to ask question to my counselor and feel satisfactory with the answers and I realize I can continue to ask questions as the needs arise.
- With this knowledge, I voluntarily consent to participate in the tele-counseling consultations including but not limited to 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 client is a minor of 18 or younger or is incapable to provide consent for the following reasons.
- I understand that confidentiality applies ages 14 and above.