Telemental Health Informed Consent

As a patient/client receiving behavioral health services through Telehealth methods, I understand:

1. Telemental Health is the delivery of behavioral health services using interactive technologies (audio, video or other electronic communications) between a provider/therapist and a patient/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 and unintentional corruption.
2. 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 type of service. I will need access to and be familiar with the appropriate technology in order to participate in the service provided. The exchange of information will not be direct (face-to-face) and any paperwork exchanged will likely be provided through electronic means or through postal delivery. During your virtual session, details of your medical history and personal health information may be discussed with you or your behavioral health professionals through the use of interactive video, audio or other telecommunication technology such as a smart phone.
3. I understand my provider/therapist regardless of what form of communication used is required by law to report child (and adult dependent) abuse and neglect, or threats to harm self or others to ensure safety.
4. I understand that if I am facing or think I may be facing an emergent situation that could result in harm to me or another person, I am not to seek telemental health consultation. Instead, I agree to seek care immediately through my own local emergency mental health or medical provider or report to the nearest emergency room for treatment. If a need for direct face-to-face services arise, please contact Valdosta Psychiatric Associates Office at 229-244-4200 to schedule a face-to-face session. I understand, it is my responsibility to contact the practitioners in my area if an emergency arises and include but are not limited to the following:
    a. 911 Emergency
    b. GCAL (Georgia Crisis & Access Line) – 800-715-4225
    c. Legacy Behavioral Crisis Center, Valdosta – 229-671-3500
    d. National Suicide Hotline – 800-273-TALK (8255)
    e. Other Local Emergency Number: ______________________

5. I may decline telemental health services at any time without jeopardizing my access to future care, services and benefits.
6. These services rely on technology that allows for greater convenience; however, there are risks in transmitting information over technology that include, but are not limited to, breaches of confidentiality, theft of personal information, disruption of service due to technology failures and technical difficulties. My provider 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. Our agreed upon method is: Via smart phone communication.

_______ Initial you have read and understand the above)

7. In the event of disruption of services, or for routine or administrative reasons, it may be necessary to communicate by other means:
   In emergency situations contact my emergency contact at:______________________
   My emergency contact's name is:____
   In case of service disruption, I will use _____________________________as an alternate means to communicate.
   For other communications:____

8. My provider/therapist may utilize alternative means of communication in the following circumstances: Video conferencing fails or phone line access is disrupted.
9. My provider/therapist will respond to communication and routine phone messages within 48 hours on business days and on the next business day following weekends or holidays.
10. It is my responsibility to maintain privacy on the patient/client end of communication. I will inform my therapist/provider in the event there are others in the room that would breach the confidentiality of the session. Insurance companies, those authorized by the patient/client and those permitted by law, may also have access to records or communications.
11. We cannot conduct a session while you are operating a moving vehicle or not in a fixed location to protect your safety and the safety of others.
12. 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).
13. I will inform my provider/therapist of my location prior to any telemental health session and provide an address and contact number.
14. My communication with my provider/therapist will be stored in the following manner: In compliance with HIPAA regulations in a secured electronic medical record file. Please be aware, all texts and emails are required to be placed in the record.
15. The laws and professional standards that apply to in-person behavioral health services also apply to telemental health services. This document does not replace other agreements, contracts, or documentation of informed consent.
16. I understand that online counseling/teletherapy based services and care may not be as complete as face-to-face services. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my provider/therapist, my condition may not improve, and in some cases may even get worse. I understand that I may benefit from online counseling/teletherapy, but that results cannot be guaranteed or assured.

____ ______________________

Patient/client Name (Printed) Date

_____________________________________ __________________________________

Patient/client Signature Provider/Therapist Signature