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INFORMATION, AUTHORIZATION, & CONSENT FOR TELEMEDICINE

Thank you so much for choosing the services that I provide. This document is designed to inform you about what you can expect from me regarding confidentiality, emergencies, and several other details regarding your treatment as it pertains to Telemedicine. Telemedicine is defined as follows:

"Telemedicine" means the delivery of health care services through the use of interactive audio and video technology, permitting real-time communication between the patient at the originating site and the provider, for the purpose of diagnosis, consultation, or treatment. For purposes of this section only, "telemedicine" does not include the use of audio-only telephone, facsimile, or email. (RCW 74.09.325.h)

Telemedicine is a relatively new concept despite the fact that many therapists have been using technology- assisted media for years. Breaches of confidentiality over the past decade have made it evident that Personal Health Information (PHI) as it relates to technology needs an extra level of protection. Additionally, there are several other factors that need to be considered regarding the delivery of Telemedicine services in order to provide you with the highest level of care.

Video Conferencing (VC): Video Conferencing is an option for us to conduct remote sessions over the internet where we not only can speak to one another, but we may also see each other on a screen. I utilize VSee. This platform is encrypted to the federal standard, HIPAA compatible, and has signed a HIPAA Business Associate Agreement (BAA). The BAA means that VSee is willing to attest to HIPAA compliance and assumes responsibility for keeping our VC interaction secure and confidential. If we choose to utilize this technology. You are responsible for initiating the connection with me at the time of your appointment.

I strongly suggest that you only communicate through a computer or device that you know is safe (e.g., has a firewall, anti-virus software installed, is password protected, not accessing the internet through a public wireless network, etc.).

Please communicate only through devices that you know are secure as described above. It is also your responsibility to choose a secure location to interact with technology-assisted media and to be aware that family, friends, employers, co-workers, strangers, and hackers could either overhear your communications or have access to the technology that you are interacting with. Additionally, you agree not to record any Telemedicine sessions.

Communication Response Time

I'm required to make sure that you're aware that I'm located in the Northwest and I abide by Pacific Standard Time. My practice is considered to be an outpatient facility, and I am set up to accommodate individuals who are reasonably safe and resourceful. I do not carry a beeper nor am I available at all times. If at any time this does not feel like sufficient support, please inform me, and we can discuss additional resources or transfer your case to a therapist or clinic with 24-hour availability. I will return phone calls within 24 hours. However, I generally do not return calls or emails on weekends or holidays. If you are having a mental health emergency and need immediate assistance, please follow the instructions below.

In Case of an Emergency

If you have a mental health emergency, I encourage you not to wait for communication back from me, but do one or more of the following:

- Call the crisis line 1.800.584.3578
- Call 911.
- Go to the emergency room of your choice.

Emergency Procedures Specific to Telemedicine Services

There are additional procedures that we need to have in place specific to Telemedicine services. These are for your safety in case of an emergency and are as follows:

· You understand that if you are having suicidal or homicidal thoughts, experiencing psychotic symptoms, or in a crisis that we cannot solve remotely, I may determine that you need a higher level of care and Telemedicine services are not appropriate.

· I require an Emergency Contact Person (ECP) who I may contact on your behalf in a life-threatening emergency only. Please write this person's name and contact information below. You will verify that your ECP is willing and able to go to your location in the event of an emergency. Additionally, if either you, your ECP, or I determine necessary, the ECP agrees take

you to a hospital. Your signature at the end of this document indicates that you understand I will only contact this individual in the extreme circumstances stated above. Please list your ECP here:

Name: _____ Phone: _____

· You agree to inform me of the address where you are at the beginning of every Telemedicine session.

· You agree to inform me of the nearest mental health hospital to your primary location that you prefer to go to in the event of a mental health emergency (usually located where you will typically be during a Telemedicine session). Please list this hospital and contact number here:

Hospital: _____ Phone: _____

In Case of Technology Failure

During a Telemedicine session, we could encounter a technological failure. The most reliable backup plan is to contact one another via telephone. Please make sure you have a phone with you, and I have that phone number. If we get disconnected from a video conferencing or chat session, end and restart the session. If we are unable to reconnect within ten minutes, please call me. If we are on a phone session and we get disconnected, please call me back or contact me to schedule another session. If the issue is due to my phone service, and we are not able to reconnect, I will not charge you for that session.

The structure and cost of Telemedicine sessions are exactly the same as face-to-face sessions described in my Professional Disclosure Statement. I agree to provide Telemedicine therapy for the fee of $100 per 50 minute session. If you are not using insurance, please sign the Credit Card Payment Form which indicates that I may charge your card without you being physically present. Your credit card will be charged at the conclusion of each Telemedicine interaction. This includes any therapeutic interaction other than setting up appointments. Visa, MasterCard, Discover, or American Express are acceptable for payment, and I will provide you with a receipt of payment and the services that I provided. The receipt of payment & services completed may also be used as a statement for insurance if applicable to you

Insurance companies have many rules and requirements specific to certain benefit plans. At the present time, many do not cover Telemedicine services. Unless otherwise negotiated, it is your responsibility to find out your insurance company's policies and to file for insurance reimbursement for Telemedicine

services. As stated above, I will be glad to provide you with a statement for your insurance company and to assist you with any questions you may have in this area.

You are also responsible for the cost of any technology you may use at your own location. This includes your computer, cell phone, tablet, internet or phone charges, software, headset, etc.

Cancellation Policy

In the event that you are unable to keep either a face-to-face appointment or a Telemedicine appointment, you must notify me at least 24 hours in advance. If such advance notice is not received, you will be financially responsible for the session you missed. Please note that insurance companies do not reimburse for missed sessions.

Limitations of Telemedicine Therapy Services

The ideal situation is to mix Telemedicine and in-person sessions. Location can be a barrier to making in-person sessions so I am pleased to be able to offer this service. I think it is important to highlight some of its limitations. Primarily, there is a risk of misunderstanding one another when communication lacks visual or auditory cues. For example, if video quality is lacking for some reason, I might not see a tear in your eye. Or, if audio quality is lacking, I might not hear the crack in your voice that I could easily pick up if you were in my office.

There may also be a disruption to the service (e.g., phone gets cut off or video drops). This can be frustrating and interrupt the normal flow of personal interaction.

Please know that I have the utmost respect and positive regard for you and your wellbeing. I would never do or say anything intentionally to hurt you in any way, and I strongly encourage you to let me know if something I've done or said has upset you. I invite you to keep our communication open at all times to reduce any possible harm.

Face-to Face

If we agree that Telemedicine services are the primary way we choose to conduct sessions, I prefer to have one face-to-face meeting at the onset of treatment and if not, at some point that we are working together. I prefer for this meeting to take place in my therapy office. If that is not possible, we will utilize video conferencing as described above. During our first session, I will require you to show a valid picture ID and another form of identity verification such a credit card in your name. At this time, you will also choose a password, phrase, or number which you will use to identify yourself in all future sessions. This procedure prevents another person from posing as you.

Consent to Telemedicine Services

In summary, technology is constantly changing, and there are implications to all of the above that we may not realize at this time. Feel free to ask questions, and please know that I am open to any feelings or thoughts you have about these and other modalities of communication and treatment.

Please print, date, and sign your name below indicating that you have read and understand the contents of this form, you agree to these policies, and you are authorizing me to utilize the Telemedicine methods discussed.

_____ Client Name (Please Print) Date

_____ Client Signature

Date: _____

If Applicable:

_____ Parent's or Legal Guardian's Name (Please Print) Date

_____ Parent's or Legal Guardian's Signature

My signature below indicates that I have discussed this form with you and have answered any questions you have regarding this information.

_____ _____ Therapist's Signature Date

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