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Consent and Agreement for Telebehavioral Health services

Introduction of Telebehavioral Health:

As a client or patient receiving behavioral services through telebehavioral health technologies, I understand that:

❏ Teletherapy/telebehavioral 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 telebehavioral 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.

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.

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.

Risks of Technology:

❏ I understand that telebehavioral 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.

Initials:_____

❑ 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.

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 telebehavioral health consultation, details of my medical history and personal health information may be discussed with myself or other behavioral health care professionals through the use of interactive video, audio or other telecommunications technology.

Local Practitioners:

❑ If a need for direct, in-person (non-emergency) services arises, it is my responsibility to contact practitioners in my area on my insurance plan or to contact my behavioral practitioner's office for an in-person appointment or my primary care physician if my behavioral practitioner is unavailable. I understand that an opening may not be immediately available in either office.

Self-Termination:

❑ I may decline any telebehavioral health services at any time without jeopardizing my access to future care, services, and benefits. However this service provider may not be able to provide other services depending on health and other conditions.

Modification Plan:

❑ 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.

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 the case of normal communication services being disrupted, Dr. Lane may not be reachable except by phone or email. Dr Tim Lane may be working remotely and not in the Roanoke Office. Phone or email are the most reliable forms of communication.

_____

Initials:_____

Disruption of Service:

❑ Should service be disrupted

- _call Dr Lane 0-395-1670_or email him at Dr.TimLane@gmail.com__

_____

❑ For other communication

- For scheduling and administrative communication only: I will contactDr Tim Lane by phone at 940-395-1670 or by email at Dr.TimLane@gmail.com . Calls will be returned within 24 hours, 48 hours on weekends.

Emergency Care:

❑ I acknowledge, however, that if 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 telebehavioral consultation.

❑ 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 Telephone Number

_____ _____

Name Telephone Number

_____ _____

Name Telephone Number

Storage:

❑ My communication exchanged with my practitioner via telehealth will not be recorded by me or by my practitioner.

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.

Initials:_____

Confirmation of Agreement:

My health care provider has explained how the telehealth service is performed and how it will be used for my treatment. My health care provider has also explained how the telehealth service will differ from in-person services, including but not limited to emotional reactions that may be generated by the technology.

In brief, I understand that my provider will not be physically in my presence. Instead, we will see and hear each other electronically. Some information my provider would ordinarily get in face-to-face consultation may not be available in telehealth services. I understand that such missing information could in some situations make it more difficult for my provider to understand my problems and to help me get better. My provider will be unable to touch me or to render any emergency assistance.

I understand that telehealth services 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 are 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.

The alternatives to the telehealth services 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 services do not necessarily eliminate my need to see a specialist in person, and I have received no guarantee as to telehealth services' effectiveness.

I unconditionally release and discharge Dr Tim Lane of Timothy M Lane, Ph.D. PLLC, its affiliates, agents, employees; and my provider and his or her designees from any liability in connection with my participation in the remote telehealth psychotherapy sessions.

I have read this document carefully and fully understand the benefits and risks. I have had the opportunity to ask any questions I have and have 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.

_____

Client Printed Name

_____ _____

Signature of Client or Legal Guardian Date

_____

Signature of Practitioner

Initials:_____