

**P.O. Box 996**

**Eastsound, WA 98245**

**C: 206.399.7741**

**INFORMATION, AUTHORIZATION, & CONSENT FOR TELEHEALTH**

Thank you so much for choosing the services that I provide. This document is provided in addition to my Professional Disclosure statement to inform you about what you can expect from me regarding confidentiality, emergencies, and several other details regarding your treatment as it pertains to telehealth.

Telehealth 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 a platform that is encrypted to the federal standard, HIPAA compatible, and has signed a HIPAA Business Associate Agreement (BAA). The BAA means that my telehealth platform is willing to attest to HIPAA compliance and assumes responsibility for keeping our 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.

Please do not access telehealth services in a location or manner that puts your safety at risk. This may include, but is not limited to, accessing telehealth while operating a motor vehicle. In such situations, I will ask you to disconnect from the session and rejoin as soon as you are able to do so safely.

Please do not record your sessions or any portion of the session without the explicit consent of all participants. I will not record our sessions without your prior permission.

# Communication Response Time

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 pager 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 am generally able to return phone calls within 48 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 National Crisis Line at 866.427.4747
* Call 911 or 988.
* 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 telehealth services. These are for your safety in case of an emergency and are as follows:

* + 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 that services via telehealth may no longer be appropriate.
	+ I require an Emergency Contact Person (ECP) who I may contact on your behalf in an emergency or crisis situation 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 to take you to a hospital. Your signature at the end of this document indicates that you understand I will only contact this individual when I determine doing so is necessary to avoid or minimize an imminent threat of harm to you or to any third party. Please list your ECP here:

Name:

Phone:

At the initiation of our therapeutic relationship, I will ask you to provide me with the following contact information if you and I are in different geographic locations:

• Your local hospital emergency room phone number; and

• Your local crisis line phone number.

At the beginning of each session, I will ask you to provide me with the following information if it has changed:

• Your physical location and address.

• A phone number I can use to contact you in case of technology failure or other loss of internet connection during our telehealth session.

• An email address I can use to contact you as an alternative if we cannot connect via phone.

# In Case of Technology Failure

During a telehealth 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 video conferencing or a 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.

**Audio-Only Telehealth Billing**

Under Washington law, a healthcare provider may bill a client or the client’s insurance for audio-only telehealth sessions only with the prior consent of the client. If you would like to have the occasional option to engage in audio-only telehealth services, you may initial below:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (initial) if you consent to billing for audio-only telehealth services.

**Insurance Billing**

Insurance companies have many rules and requirements specific to certain benefit plans. Unless otherwise negotiated, it is your responsibility to find out your insurance company’s policies and to file for insurance reimbursement for telehealth services. 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.

# Limitations of Telehealth Services

The ideal situation is to mix telehealth and in-person sessions. Location or health concerns 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 more 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 always keep our communication open to reduce any possible harm.

If you are located outside of the State of Washington, the counseling services I am allowed to provide to you may be limited or prohibited. If you are located outside of the State of Washington, we will discuss what services I may be able to provide to 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 telehealth 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

If signing on behalf of a minor child under 13 years of age, do you have legal authority to consent to services on behalf of your child? \_\_\_\_\_yes \_\_\_\_\_no