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Tele-Mental Health Informed Consent

Introduction of Tele-mental Health:
_____ As a patient receiving mental health services through tele-mental health technologies, I understand:

_____ Tele-mental 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 tele-mental 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.

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.

Billing & Financial Responsibility:
_____ I understand all efforts will be made to bill my health insurance for tele-mental health services. I understand I am responsible for charges incurred for the telebehavioral health services based on my insurance plan.

Technology Requirements:
_____ I will need access to, and familiarity with, the appropriate technology in order to participate in the service provided. My practitioner will inform me of the technology to be used and how I will enter the tele-mental health session.

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

Local Practitioners:
_____ If a need for direct, in-person services arises, it is my responsibility to contact my practitioner to determine the best course of action or I may contact Parkview Behavioral Health Assessment Center at (260) 373-7500, or St. Joseph Behavioral Health at (260) 425-3606. I also understand I can call 911 in emergency situations or proceed to my nearest emergency room.

Self-Termination:
_____ I may decline any tele-mental health services at any time without jeopardizing my access to future care, services, and benefits.

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

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 emergency situations contact number of patient ________________________________

Location of client:
____ It is understood that when participating in tele-mental health session that my location will be the address of record for me unless otherwise identified by myself the client and at that time, I will identify the address of my location.

Disruption of Service:
_____ Should service be disrupted practitioner should call ______________________________

Practitioner Communication:
_____ My practitioner may utilize alternative means of communication in the following circumstances:

_____ Tele-mental session was disrupted due to internet failure of any form.

_____ Poor reception preventing effective communication.

Client Communication:
_____ It is my responsibility to maintain privacy on the patient end of communication. Insurance companies, those authorized by the patient, and those permitted by law may also have access to records or communications.

_____I agree I will not audio or video tape the telebehavioral session

Storage:
_____My communication exchanged with my practitioner will be documented by the practitioner in the form of a progress note placed in my medical record.

Laws & Standards:
_____ The laws and professional standards that apply to in-person mental/behavioral services also apply to telehealth services. This document does not replace other agreements, contracts, or documentation of informed consent.

Confirmation of Agreement:

____
Client Printed Name

____
Signature of Client or Legal Guardian Date

____
Printed Name of Practitioner Signature of Practitioner Date: