**Telebehavioral Health Informed Consent**

*Please read over the following document and check each box to indicate that you have read and agree with the statement next to the box. Please sign electronically below and send this form back via the therapy portal.*

**Introduction of Telebehavioral Health:**

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

[ ] 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.

**Release of Information:**

[ ]  I authorize the release of any information pertaining to me determined by my practitioner, my other health care practitioners or by my insurance carrier to be relevant to the consultation(s) or processing of insurance claims, including but not limited to my name, Social Security number, birth date, diagnosis, treatment plan and other clinical or medical record information.

**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.*

*[ ] Recording of services without the consent of the therapist is NOT allowed. If we discover that you are recording without the permission of the therapist, we terminate services immediately.*

**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.

[ ]   Regardless of the sophistication of today’s technology, some information my practitioner would ordinarily get in in-person consultation may not be available in teleconsultation. I understand that such missing information could in some situations make it more difficult for my practitioner to understand my problems and to help me get better. My practitioner will be unable to physically touch me or to render any emergency assistance if I experience a crisis.

**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 technolog*y.

[ ] Ethernet connections are recommended and using wifi connections may compromise the signal and/or the confidentiality of communication or what is communicated. If you are going to use wifi, we recommend you do not use a wifie connection that is shared or owned by a business or other entity as confidentiality cannot be guaranteed.

**Local Practitioners:**

[ ]  If a need for direct, in-person services arises, it is my responsibility to contact practitioners in my area 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.

[ ] I further understand that I do not have to answer any question that I feel is inappropriate or whose answer I do not wish persons present to hear; that any refusal to participate in the consultation(s) or use of technology will not affect my continued treatment and that no action will be taken against me.

[ ] I acknowledge, however, that diagnosis depends on information, and treatment depends on diagnosis, so if I withhold information, I assume the risk that a diagnosis might not be made or might be made incorrectly.

[ ] Were that to happen, my telehealth-based treatment might be less successful than it otherwise would be, or it could fail entirely.

**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.

[ ] 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.

[ ] I represent that I am using my own equipment to communicate and not equipment owned by another, and specifically not using my employer’s computer or network. I am aware that any information I enter into an employer’s computer can be considered by the courts to belong to my employer and my privacy may thus be compromised.

[ ] 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.

**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:

**Limits of Confidentiality:**

[ ] I also understand that, under the law, and regardless of what form of communication I use in working with my practitioner, my practitioner may be required to report to the authorities information suggesting that I have engaged in behaviors that endanger others.

**Disruption of Service:**

[ ] Should service be disrupted every attempt will be made to re-connect the services.

**Practitioner Communication:**

[ ]  For other communication, text reminders, phone calls or a secure email communication will be used. Statements regarding client balances will be emailed securely as well.

[ ]  Clients can use the Therapy Portal for Renew Counseling to request and cancel appointments.

**Client Communication:**

[ ]  It is my responsibility to maintain privacy on the client end of communication. Insurance companies, those authorized by the client, and those permitted by law may also have access to records or communications.

**Storage and Records:**

[ ] My communication exchanged with my practitioner will be stored in written form in a note; stored in the Electronic Health Record for the practice and will in no way be video or audio taped without the consent and signed permission of the client.

[ ] I understand that I am ordinarily guaranteed access to my records and that copies of records of consultation(s) are available to me on my written request.

[ ] I also understand, however, that if my practitioner, in the exercise of professional judgment, concludes that providing my records to me could threaten the safety of a human being, myself or another person, he or she may rightfully decline to provide them. If such a request is made and honored, I understand that I retain sole responsibility for the confidentiality of the records released to me and that I may have to pay a reasonable fee to get a copy.

[ ] Additionally, I understand that my records may be used for telehealth program evaluation, education, and research and that I will not be personally identified if such a use occurs.

[ ] I hereby authorize these disclosures to take place without prior written consent.

**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.

**Contact Information:**

[ ] I have received a copy of my practitioner’s contact information, including his or her name, telephone number, pager and/or voice mail number, business address, mailing address, and e-mail address (if applicable).

[ ] I have also been provided with a list of local support services in case of an emergency. I am aware that my practitioner may contact the proper authorities and/or my designated, local contact person in case of an emergency.

**Confirmation of Agreement:**

I am responsible for the fees incurred for these services and am ultimately liable for any unpaid balances once all claims have been filed and submitted by Renew Counseling, LLC.

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Client Printed Name

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Signature of Client or Legal Guardian

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Printed Name of Practitioner

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Signature of Practitioner