HOPE CLINIC
a community health center

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TELEHEALTH CONSENT FORM FOR MENTAL HEALTH SERVICES

Informed Consent for Tele Mental Health Services

The following information is provided to clients who are seeking Tele Mental Health services. This document covers your rights, risks and benefits associated with receiving services, my policies and your authorization. Please read this document carefully, note any questions you would like to discuss and sign.

Tele Mental Health Services Defined:

Tele Mental Health Services means the remote delivering of health care services via technology assisted media. This includes a wide array of clinical services and various forms of technology. The technology includes but is not limited to video, internet, a smartphone, tablet, PC desktop system or other electronic means. The delivery method must be secured by two-way encryption to be considered secure. Synchronous (at the same time) secure video chatting is the preferred method of service delivery.

Limitations of Tele Mental Health Therapy Services:

While Tele Mental Health Services offers several advantages such as convenience and flexibility, it is an alternative form of therapy or adjunct to therapy and thus may involve disadvantages and limitations. For example, there may 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. 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 various details such as facial expressions. Or if audio quality is lacking, I might not hear differences in your tone of voice that I could easily pick up if you were in my office. Additionally, the therapy office decreases the likelihood of interruptions. However, there are ways to minimize interruptions and maximize privacy and effectiveness. As the behavioral health provider, I will take every precaution to insure technologically secure and environmentally private sessions.

Client Responsibilities for Tele Mental Health Therapy Services:

The virtual sessions can only be conducted while the client is within the state of Texas. The virtual sessions must be conducted on a Wi-Fi connection for the best connections and to minimize disruption. It is strongly suggested that you only communicate through a device that you know is safe and technologically secure (e.g. has a firewall, anti-virus software installed, is password protected, not accessing the internet through a public wireless network, etc.) Do not use “auto-remember” names and passwords.

Make sure you have checked your company’s policy before using a work computer for personal communication. As the client, you are responsible for finding a private, quiet location where the sessions may be conducted. **Sessions are not able to take place if other individuals are present in your location.** Consider using a “do not disturb” sign/note on the door.

Training:

Providers conducting the Tele Mental Health visit (as applicable based on licensure regulations) have received the 15 hours of required training for providing Tele Mental Health services in the state of Texas by the LMFT board. ttps://www.dshs.texas.gov/mft/ The LPC board does not currently have a Tele Mental Health training requirement. https://www.dshs.texas.gov/counselor

Identity and Location:

I am required to verify your identity and location at the start of each session.

In Case of Technology Failure:

I understand that during a Tele Mental Health session we could encounter a technological failure. Difficulties with hardware, software, equipment, and/or services supplied by a 3rd party may result in service interruptions. If something occurs to prevent or disrupt any scheduled appointment due to technical complications and the session cannot be completed via online video conferencing, please call the therapist back at the HOPE Clinic phone number. Please make sure you have a phone with you and that I have that phone number. It may be necessary to reschedule if there are problems with connectivity.

Structure and Cost of Sessions:

HOPE Clinic offers face-to-face psychotherapy and psychiatry services when appropriate and available. However, based on your ability to make in-person sessions and circumstances, we may provide virtual psychotherapy and psychiatry services if the treatment needs determine that Tele Mental Health Services are appropriate for you. The determination will be made based on severity of symptoms, type of treatment, client access to secure online communication, and client ability to use the technology. If appropriate, you may engage in either face-to-face sessions, Tele Mental Health or both.

Payment and visit fees apply for these Tele Mental Health visits as they do for a regular in office visit based on the HOPE Clinic sliding scale fee structure or your insurance requirements.

Email, Social Media, Patient Portal Message:

Email is not a secure means of communication and may compromise your confidentiality. You also need to know that I am required to keep a summary of all emails as part of your clinical record that addresses anything related to therapy. If you are in a crisis, do not communicate this to HOPE Clinic via email or the patient portal or on social media. Instead, please see below under "Emergency Management Plan."

Interactive Video, Electronic Medical Record, Secure Email for Documents:

HOPE Clinic uses a secure electronic platform within the eClinical Works system. Your record will be maintained by HOPE Clinic according to regulations for mental health records.

Cancellation Policy:

In the event that you are unable to keep either a face-to-face appointment or a Tele Mental Health appointment, we request that you notify the office at least 24 hours in advance by calling the office at 712-773-0803.

Emergency Management Plan:

When calling or messaging, I can usually return a call or message within 24 hours. If I am unavailable in the event of an emergency, it is imperative you are aware of resources in your area. As a precaution, please identify two (2) nearby emergency hospitals below. In addition, you will need to provide information for an emergency contact person. These all must be completed to participate in Tele Mental Health services.

1. Hospital Name and Location:

_____

_____

Hospital Telephone Number: _____

2. Hospital Name and Location:

_____

_____

Hospital Telephone Number: _____

Emergency Contact Person: _____

Relationship: _____ Phone Number: _____

You may alternatively follow this plan:

1. Call Lifeline at (800) 273-8255 (National Crisis Line)
2. Call 911
3. Go to the emergency room of your choice.

I agree to take full responsibility for the security of any communications or treatment on my own computer or electronic device and in my own physical location. I understand I am solely responsible for maintaining the strict confidentiality of my user ID, password, and/or connectivity link. I shall not allow another person to use my user ID or connectivity link to access services. I also understand that I am responsible for using this technology in a secure and private location so that others cannot hear my conversations.

I understand that there will be no video or audio recording of any of the online sessions and that all information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without my written permission, except where disclosure is required by law. I understand that it may be necessary during the telehealth visit for the provider or provider office staff to take a picture within the telehealth platform to document my attendance. These pictures will only be used for purposes of documentation within the health record and are not saved by the provider or staff. I consent to have pictures taken for this purpose during the telehealth visit.

Consent for Tele Mental Health Services Treatment:

I voluntarily agree to receive online therapy and/or psychiatry services for an assessment, continued care, treatment, or other services and authorize HOPE Clinic (Asian American

Health Coalition) to provide such care, treatment or services as are considered necessary and advisable. I understand and agree that I will participate in the planning of my care, treatment or services and that I may withdraw consent for such care, treatment or services that I receive through HOPE Clinic (Asian American Health Coalition)at any time. By signing this Informed Consent, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

_____ _____

Date Time

_____

Patient/Client Signature

_____

Parent/Guardian/Legal Representative Signature *(if minor or needed otherwise)*