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Technology within a Therapeutic Setting
Consent, Polices, Limitations, and Agreement Form

Telemedicine Informed Consent

This form is to review the limitations, risks, and benefits of technology within a therapeutic setting. This includes email, phone, text and video. The provider will ultimately determine if you are appropriate for this type of treatment.

Benefits:

The benefits to technology are:

1. Reduces the stigma of obtaining mental health services.
2. More convenient for clients to get the help they need.
3. Reduces the overall costs due to not having to drive to and from and office.
4. Reduces the wait time for scheduling office appointments.
5. Increased availability of services to people who are unable to leave the home or have difficulties with transportation.

Limitations:

It is important to note that there are limitations to technology that can affect the quality of the session(s). These limitations include but are not limited to the following:

1. Because we are not in person, the provider has limitations to reading your body language, or your non-verbal reactions to what is being discussed.
2. Due to technology limitations the provider may not hear all of what you are saying. If you feel the provider has not heard you, please make sure to repeat what you were saying.
3. Technology may fail before or during the session.
4. Although every effort is made to reduce confidentiality breach, we are using technology platforms, and the provider does not have any control over whether or not the protection of confidentiality used by the platform; is working as it is supposed to be, at all times.
5. The provider will inform you of which technology platforms they are using and it is your responsibility to read, understand, and agree to that platform's rules and limitations.

Logistics:
When the provider is using technological platform, they will be in private location to ensure your privacy. It is your responsibility to be in a location that is safe and confidential to protect your privacy. If you choose a place where others can hear you the provider cannot be responsible for protecting your confidentiality. Every effort MUST be made on your part to protect your own confidentiality.

Connection Lost:
If we lose our connection during a video or phone session, the provider will call you to try and troubleshoot the reason for the lost connection. If the reason the connection is lost occurs on your part i.e. battery dying, bad reception, etc. you could still be charged for the entire session. If the loss for connection is a result of something caused by the provider. The provider will do everything they can to troubleshoot the problem and may offer other options such as completing the session using other technology or may need to reschedule.

Recording of Sessions:
Please note the recording of audio/video, photographing, screenshots, streaming, etc of any kind is NOT permitted and are grounds for termination of the client-therapist relationship.

Your Location:
The provider can only practice in the state(s) they are licensed in. That means you must reside in and be participating from the state the provider is licensed. You agree to inform the provider if your location has changed.

In Case of Emergencies:

Before each session begins the provider will request the address for which you are currently located and will use this information to give to authorities in case of a crisis or emergency. If for some reason you and provider get disconnected and you are in crisis/emergency, you agree to call 911, go to your local emergency room immediately or contact the National Suicide Hotline 800-273-TALK (8255). If the provider has concerns about your safety including you being a danger to yourself or others at ANYTIME during a session, the provider will call 911.

The provider is required to keep an emergency contact for you. This contact can/will be used during a crisis/emergency.

Please list the person's first and last name, relationship and phone number(s) of your emergency contact:

_____

Full Name Relationship Number(s)

_____

Full Name Relationship Number(s)

Please list any alternate numbers you can be contacted at in case of a crisis/emergency:

_____

Number(s)

I _____ hereby consent to engage in telemedicine (e.g., internet, email or telephone-based therapy) with (Claudette Waite/ Devyn Davis/Shana McKissick/NewPoint of View Counseling) for psychotherapy treatment. I understand that telemedicine includes the practice of health care delivery, including mental health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, and/or data communications. I understand that telemedicine also involves the communication of my medical/mental health information, both orally and visually, to other health care practitioners.

I understand that I have the following rights with respect to telemedicine:
(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment or risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

(2) The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality including, but not limited to: reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. (See also Office Policies and HIPAA Notice of Privacy Practices forms, provided to me, for more details of confidentiality and other issues.)

I also understand that the dissemination to researchers or other entities, of any personally identifiable images or information from the telemedicine interaction shall not occur without my written consent.

(3) I understand that there are risks and consequences from telemedicine. These may include, but are not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; the electronic storage of my medical information could be accessed by unauthorized persons; and/or misunderstandings can more easily occur, especially when care is delivered in an asynchronous manner.

In addition, I understand that telemedicine-based services and care may not yield the same results nor be as complete as face-to-face service. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic service (e.g. face-to-face service), I will be referred to a psychotherapist in my area who can provide such service. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy and that, despite my efforts and the efforts of my psychotherapist, my condition may not improve and in some cases may even get worse.

(4) I understand that I may benefit from telemedicine, but results cannot be guaranteed or assured. The benefits of telemedicine may include, but are not limited to: finding a greater ability

to express thoughts and emotions; transportation and travel difficulties are avoided; time constraints are minimized; and there may be a greater opportunity to prepare in advance for therapy sessions.

(5) I understand that I have the right to access my medical information and copies of medical records in accordance with Arizona Law, that these services may not be covered by insurance, and that, if there is intentional misrepresentation, therapy will be terminated.

I have read and understand the information provided above, which has also been explained to me verbally. I have discussed it with my psychotherapist and all of my questions have been answered to my satisfaction.

Client Name _____Date _____

Signature: _____