Telehealth Informed Consent

Amigo Family Counseling, LLC.
355 E Campus view Blvd, Ste 105
Columbus, OH 43235

Phone: (614) 310-1234
amigofamcounsel105@gmail.com
AmigoFamilyCounseling.com

Definitions of Telehealth

For the purposes of this consent form, Telehealth refers to both Telepsychology and Electronic Service Delivery. Telepsychology means the practice of psychology or school psychology, including psychological and school psychological supervision, by distance communication technology such as but not necessarily limited to telephone, email, Internet-based communications, and videoconferencing. Electronic Service Delivery is defined as counseling, social work or marriage and family therapy in any form offered, rendered, or supported by electronic or digitally-assisted approaches, to include when the psychologist, counselor, social worker or marriage and family therapist and the client are not located in the same place during delivery of services or when electronic systems or digitally-assisted systems are used to support in-person face to face therapy. Telehealth includes the practice of psychological health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data. Amigo Family Counseling, LLC (AFC) utilizes secure, encrypted audio/video transmission software to deliver videoconference Telehealth services.

Telehealth is not appropriate for all psychological problems and clients and decisions regarding the appropriate use of Telehealth are made on a case-by-case basis.

Telehealth services require access to, and familiarity with, the appropriate technology to participate in the service provided and/or use of a personal aid or assistive device to benefit from the service.

Upon initial and subsequent Telehealth contacts with a client, AFC service providers will make reasonable efforts to verify the identity of the client, their location and the safety and privacy of their location. It is the client's or legal guardian's responsibility to maintain privacy on the client end of communication.

In emergencies, in the event of disruption of service, or for routine or administrative reasons, it may be necessary to communicate by other means. AFC requires an alternative means of contacting clients and will provide clients an alternative means for contacting their AFC service provider or the AFC office.

If no agreement was made prior to receiving Telehealth services, AFC and the client will establish a written agreement detailing how a client or guardian will access crisis/emergency services in their geographical area, in instances such as, but not limited to, experiencing a suicidal or homicidal crisis. Additionally, an Emergency Contact (minimum of one) is required. AFC staff, at their discretion and with appropriate written consent, may interact with a client's Emergency Contact in order to verify their identity, contact information, availability and willingness to serve as a support person in the event of an emergency/crisis. In the event that the client is a Minor, an AFC Service Provider may require a parent or legal guardian be present at the location, though not necessarily in the same space/room.

The laws and professional standards that apply to in-person psychological or counseling services also apply to Telehealth services. This document does not replace other agreements, contracts, or documentation of informed consent.

As a client receiving Telehealth services, I understand:

1. The laws that protect the confidentiality of my personal information also apply to Telehealth. As such, I understand that the information disclosed by me during the course of my sessions 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 toward an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the Telehealth interaction to other entities shall not occur without my written consent.
2. AFC does not electronically record Telehealth services.
3. As a condition of receiving Telehealth services I agree not to record or disseminate my Telehealth services in any manner whatsoever (audio-visually, screenshotting, etc.) I understand any failure to abide by this term may result in AFC terminating any and all professional services.
4. I understand that I have the right to withhold or withdraw my consent to the use of Telehealth in the course of my care at any time, without affecting my right to future care or treatment.
5. I understand that I may expect anticipated or potential benefits such as greater convenience in service delivery, improved access to care and more efficient evaluation and management from the use of Telehealth in my care, but that no results can be guaranteed or assured.
6. I understand there are risks and potential consequences from transmitting information over the internet in order to receive Telehealth services, including, but not limited to, the possibility, despite reasonable efforts on the part of the service provider, that any of the following could occur: breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties. My Telehealth service provider and I will regularly reassess the appropriateness of continuing to deliver services to me through the use of technology.
7. I understand that Telehealth videoconference sessions require an email invitation from the AFC staff member I will be interacting with.
8. I understand that any and all email correspondence from AFC is not encrypted. I acknowledge my understanding that unencrypted emails carry with them certain levels of risk, for example, the information in the email could be read by an unintended 3rd party. Emails contain information which could be used to identify me such as my email and internet (IP) addresses. I understand these risks and waive my right to encrypted emails from AFC. As a covered entity, AFC will not be responsible for any unauthorized access. I request any and all ZOOM Meeting "invitations" necessary to receive Telehealth services be sent to the email address on file with AFC or to the following email address.

_____.

I understand I am responsible for updating AFC staff of any changes to my email address.

9. In the case of online group therapy sessions, I understand there are additional limitations and risks involved in using Telehealth. Specifically, I agree to respect the confidentiality of others I have contact with in group sessions. I understand that it is my responsibility to refrain from sharing information provided with anyone who is not a client or staff member present in sessions as this would be a breach of my confidentiality agreement with my AFC service provider.
10. I understand the alternatives to counseling through Telehealth as they have been explained to me, and in choosing to participate in Telehealth, I am agreeing to participate using video conferencing technology.
11. I understand that my healthcare information may be shared with other authorized individuals for scheduling and billing purposes.
12. I understand that my express consent is required to forward my personally identifiable information to a third party.
13. I understand that I have a right to access my medical or treatment information and copies of my medical or treatment records in accordance with applicable Ohio law.
14. I understand and agree that certain situations, including emergencies and crises, are generally deemed inappropriate for Telehealth services by AFC staff. If I am in crisis or in an emergency, I should immediately seek help from a hospital or crisis-oriented health care facility in my immediate area or call 911.
15. I understand AFC recommends using secure internet connections as public access/Wi-Fi can disrupt or compromise confidentiality. AFC further recommends that a quiet, isolated place should be sought for sessions to limit the possibility of interruption and/or breach of confidentiality. In the event that a Telehealth meeting is cut off I will wait for the connection to resume or until my AFC service provider contacts me telephonically.
16. When applicable, I understand that it is my responsibility to consider employer, school/academic institutions and other relevant third-party policies related to the use of computers and other electronic devices for personal communication.
17. As a consumer of mental health services, I have the right to verify the licensure status of my AFC service provider and can do so by typing the following internet link into a browser search:

    https://elicense.ohio.gov/oh_homepage

Payment for Telehealth Services

AFC Telehealth fees are the same as the in-office fee for services rates. When applicable, Amigo Family Counseling will bill insurance for Telehealth services with the required codes and modifiers. The client or legal guardian is responsible for checking with his or her insurance company to determine if the insurance company will reimburse for Telehealth sessions

(Telehealth may be defined by insurance companies as electronic service delivery, tele-behavioral health, or e-therapy) and if there are any coverage limitations. In the event that insurance does not cover Telehealth, the individual will be responsible to pay out-of-pocket costs unless other payment arrangements have already been established (including but not limited to county funding or out of pocket with credit adjustment).

Patient Consent to the Use of Telehealth

By my signature below, I hereby state that I have carefully read, understood, and agree to the terms of this document. I have been given sufficient opportunity to ask questions and receive answers about Telehealth and I understand the risks and benefits related to the use of Telehealth services. I hereby give my informed consent to participate in the use of Telehealth services for treatment under the terms described herein.

I understand that any client who is a minor (Under 18 years of age) or does not have legal guardianship over him or herself will require the signature of a parent or legal guardian.

_____
Client Name

_____ _____
Client Signature Date

_____ _____
Parent or Guardian Name/Signature Date
(If client is a minor)

_____
AFC Service Provider Name

_____ _____
AFC Service Provider Signature Date