ASSOCIATED PSYCHOLOGISTS & COUNSELORS, LLC

1306 NORTH 13TH STREET; SUITE 100

NORFOLK, NE 68701

(402) 371-8218

Informed Consent for Telehealth Services

Name: Last _____ First _____ M.I. _____

Birth Date: _____ Location during telehealth services (State): _____

Home Phone: _____ Work Phone: _____ Cell: _____

Email Address: _____ Provider's Name: David A. Mitchell, PhD

Telehealth Services to be provided:_____

Health Care Practitioner to be seen:_____

Location of Health Care Practitioner:_____

Telehealth Services: Services delivered by a health care practitioner that utilize an interactive audio and video telecommunications system that permits real-time communication between the health care practitioner at the distant site and the client at the originating site. Telehealth services do not include a telephone conversation, electronic mail message, facsimile transmission between a health care practitioner and a client, a consultation between two health care practitioners and a synchronous "store and forward" technology.

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telehealth, and that no information obtained in the use of telehealth which identifies me will be disclosed to researchers or other entities without my consent.
2. 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.
3. I understand I may have to travel to see a health care practitioner in-person if I decline the telehealth service.
4. If I decline the telehealth services, the other options/alternatives available for me, including in-person services, are as follows: _____
5. I understand I have access to all medical information resulting from the telehealth consultation as provided by law for patient access to his or her medical records.
6. Dissemination of any patient identifiable images or information from the telehealth consultation to researchers or other entities shall not occur without the written consent of the patient and/or their parent/guardian.
7. I will be informed of all people who will be present at all sites during my telehealth service.
8. I may exclude anyone from any site during my telehealth service.
9. I may see an appropriately trained staff person or employee in-person immediately after the telehealth service if an urgent need arises OR I will be told ahead of time that this is not available.
10. If applicable, it is my responsibility to verify that my insurance provider or other payer(s) reimburses for telehealth services. Any fees not reimbursed by insurance provider or other payer(s) are my responsibility.
11. I understand that it is my responsibility to find a private place for a session where we will not be interrupted. It is best to do so in a room or area where others are not in the room and cannot overhear the conversation.
12. I understand that technology issues may occur during our session. For instance, technology may stop working. If this occurs, I will contact my provider at (402) 371-8218 to resolve the issue or to continue the session by phone.

13. Although APC will only work with HIPAA compliant telehealth companies, I understand that APC cannot guarantee that others won't be able to access our private conversation (e.g., if there is a virus or malware on my computer).
14. I understand that I may need to work with my provider to develop an emergency response plan to address a potential crisis situation should the need arise in the course of our telehealth session. This would include identifying an emergency contact person near my location who can be contacted in the case of an emergency to assist in addressing the situation. I understand that I will be asked to sign a separate release of information form so that my provider may contact this individual in the case of an emergency.
15. I understand that I will need to have a computer or phone that has both a camera and a microphone in order to participate in a telehealth session.
16. I understand that APC will do all it can to protect the privacy of all of our communications, but that it cannot guarantee that our electronic communications won't be compromised, unsecured, or accessed by others. I understand that I should take reasonable steps to help protect the security of our communications as well (e.g., by using secure networks and passwords to protect the device I am using).
17. I understand that if a technology issue occurs when I am in crisis, I should contact 911 or go to my nearest emergency room rather than waiting for the technology issue to resolve so that I can speak with my provider. If the session is interrupted and I am not having an emergency, I will wait for two (2) minutes for my provider to try to reconnect with me. I know I should contact my provider at (402) 371-8218 if I have not been contacted by the end of that two-minute period.
18. I understand that the same fee rates will apply to telehealth sessions as applied to my regular therapy sessions. If our therapy session is disconnected for any reason, I understand that I will only be charged for the amount of time I was connected with my psychologist or counselor.
19. I understand that telehealth sessions will not be digitally recorded or stored unless this is agreed to in writing by mutual consent. I know that my counselor/psychologist will maintain a written note of our progress in the same way that is done for typical therapy sessions.

I have read and understand the information provided above regarding telehealth, have discussed it with my psychologist or counselor, and all of my questions have been answered to my satisfaction. I hereby give my informed consent to the use of telehealth services in my mental health care.

_____ _____

Patient/guardian signature Date

_____

Patient/guardian name (please print)

_____

Witness to signatures

_____

Reason patient was unable to sign consent