

Consumer Name: \_\_\_\_\_ Consumer ID#: \_\_\_\_\_

**Center for Positive Change**  
***Informed Consent for Telebehavioral Health***

As a consumer/client receiving services through Telebehavioral health technologies, I,  
\_\_\_\_\_, understand the following:

(Consumer Name)

1. My Mental Health Professional (MHP) wishes me to engage in Telebehavioral health services.
2. Telebehavioral health is the delivery of behavioral health services using interactive technologies (use of audio, video, or other electronic communications) between a MHP and a consumer/client who are not in the same physical location. This will not be the same as a direct consumer/client and MHP visit due to the fact I will not be in the same location as my MHP.
3. The interactive technologies used in Telebehavioral health services incorporate network and software security protocols to protect the confidentiality of consumer/client information transmitted via any electronic channel. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption.
4. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits, and any practical alternatives have been discussed with me in a language in which I understand.

**Benefits and Limitations**

This service is provided by technology (including but not limited to video, text, apps, and email) and may not involve direct face-to-face communication. There are benefits and limitations to this service. These services rely on technology, which allows for greater convenience in service delivery and with meeting from a location of my choosing. There are risks in transmitting information over technology that include, but are not limited to, breaches of confidentiality, theft of personal information, interruptions, and disruption of service due to technical difficulties. I do not assume that my MHP has access to any or all of the technical information in Doxy.Me – or that such information is current, accurate or up-to-date. I will not rely on my MHP to have any of this information in Doxy.Me.

**Technology Requirements**

I will need access to, and familiarity with, the appropriate technology in order to participate in the service provided. Doxy.Me is the technology service used to conduct Telebehavioral health video-conferencing appointments. It is simple to use, and I will be provided with a link to enter my MHP's Doxy.me Waiting Room. I will need to access the link provided to me through Chrome or Firefox to access the Waiting Room, access to high-speed internet connection, webcam/camera access, and microphone access.

**Self-termination**

My MHP or I may decline any Telebehavioral health service at any time without jeopardizing my access to future care, services, and benefits if it is believed the video-conferencing connections

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are not adequate for the situation. I may withdraw from any and all Telebehavioral health service at any time for any reason without jeopardizing my access to future care, services, and benefits.

### **Modification Plan**

My MHP 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. In emergency situations, my MHP will attempt to contact me via phone and I am advised to contact my MHP via phone. If that is unsuccessful, I will call 911 or go to my nearest emergency room. By signing this document, I acknowledge:

1. Doxy.Me is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
2. Though my MHP and I may be in direct, virtual contact through the Telebehavioral health service, neither Doxy.Me nor the Telebehavioral health service provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
3. Doxy.Me facilitates video-conferencing and is not responsible for the delivery of any healthcare, medical advice, or care.
4. Crisis intervention services will not be provided via information and technology communications, or Telebehavioral Health Services.

### **Disruption of Service:**

Should service be disrupted, my MHP will attempt to contact me via phone to continue the session, I am advised to contact my MHP via phone. If my MHP is unable to reach me, she/he will send a text with her/his phone number for me to contact them.

### **Consumer/Client communication**

It is my responsibility to maintain privacy on the consumer/client end of the communication. Insurance companies, those authorized by the consumer/client, and those permitted by law may also have access to records or communications. To maintain confidentiality, I will not share my Telebehavioral health appointment link/login credentials with anyone unauthorized to attend the appointment. I will be provided access to any of my information that is stored or recorded but understand that doxy.me does not store any data, and data that is transmitted during video-conference is destroyed immediately when the call is terminated. I will take the following precautions to ensure that my communications are directed only to my MHP or other designated individuals:

1. I will log in to the appropriate technology assisted software.
2. I will attempt to be in a private and distraction free environment.
3. I will use earbuds/headphones that have a built-in microphone as possible to ensure privacy.

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**Laws and Professional Standards**

The laws and professional standards that apply to in-person behavioral services also apply to Telebehavioral health services. This document does not replace other agreements, contracts, or documentation of informed consent. By signing this form, I certify: That I have read, or had this form read, and/or had this form explained to me. That I fully understand its contents including the risks and benefits of the procedure(s). That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction. BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD, AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

\_\_\_\_\_  
Consumer/Client Signature (*required if 14yr or older*)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature      Relationship to Client      Date

\_\_\_\_\_  
Provider Signature/Credentials      Date