



Telebehavioral Health Informed Consent

Please initial the line beside each item listed below to indicate you have read and understand the content contained within.

Please email the completed form to me at mfunk@actts.org

Introduction of Telebehavioral Health

As a client or patient receiving behavioral services through telebehavioral health technologies, I _____ understand:
(Printed Legal Name)

___ Telebehavioral health is the delivery of behavioral health services using interactive technologies (use of audio, video or other electronic communications) between my therapist, Marc Funk, LPC, LADC and myself _____, who are not in the same physical location.
(Printed Legal Name)

___ The interactive technologies used in telebehavioral health incorporate network and software security protocols to protect the confidentiality of client/patient information transmitted via any electronic channel. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption.

Software Security Protocols:

___ Electronic systems used will incorporate network and software security protocols to protect the data to ensure its integrity against intentional or unintentional corruption.

Benefits & Limitations:

___ This service is provided by technology (including but not limited to video, phone, text, apps and email) and may not involve direct face to face communication. There are benefits and limitations to this service. *To be further outlined below*

Technology Requirements:

___ I will need access to, and familiarity with, the appropriate technology in order to participate in the service provided.

Exchange of Information:

___ The exchange of information will not be direct and any paperwork exchanged will likely be provided through electronic means or through postal delivery.

___ During my telebehavioral health consultation, details of my medical history and personal health information may be discussed with myself or other behavioral health care professionals through the use of interactive video, audio or other telecommunications technology.



Local Practitioners:

___ If a need for direct, in-person services arises, it is my responsibility to contact my behavioral health practitioner, Marc Funk, LPC, LADC for an in-person appointment or my primary care physician if my behavioral practitioner is unavailable. I understand that an opening may not be immediately available in either office.

Marc Funk, LPC, LADC may be contacted by phone at (405) 243-7742 or through e-mail at mfunk@actts.org.

Self-Termination:

___ I may decline any telebehavioral health services at any time without jeopardizing my access to future care, services, and benefits.

Risks of Technology:

___ These services rely on technology, which allows for greater convenience in service delivery. There are risks in transmitting information over technology that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties.

Modification Plan:

___ My practitioner 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
▪ Contact your local emergency room or call 9-1-1.

___ Should service be disrupted
▪ We may need to either suspend services for a brief period of time or meet in person at the practitioner's place of business until services are re-established.

Practitioner Communication:

___ My practitioner may utilize alternative means of communication in the following circumstances:

o _____
___ My practitioner will respond to communications and routine messages *within 24 business hours for non-emergent situations or within 2 hours of any identified emergent situations*

Client Communication:

___ It is my responsibility to maintain privacy on the client end of communication. Insurance companies, those authorized by the client, and those permitted by law may also have access to records or communications.

___ I will take the following precautions to ensure that my communications are private and directed only to my practitioner or other designated individuals by the following actions:



- ___ I will ensure that only those people I want to have access to my telehealth session are present physically as well as within ear-shot of my session.
- ___ I will ensure that my scheduled appointment is secured in an area I deem to be confidential and free from any distractions.
- ___ I will ensure that my scheduled appointment time does not conflict with other matters that may need my attention and therefore disrupt the telehealth session.

Storage:

- ___ My communication exchanged with my practitioner will be stored in the following manner:
 - Written forms will be stored in a paper file maintained in the practitioner’s place of business.
 - Electronic media will be stored in secure, encrypted files which may include, but are not limited to the practitioner’s billing software and Electronic Medical Record (EMR) storage systems.

Laws & Standards:

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

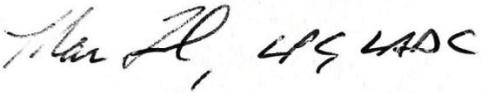
Confirmation of Agreement:

Client Printed Name

Signature of Client or Legal Guardian

Date

Marc Funk, LPC, LADC
Printed Name of Practitioner


Signature of Practitioner Date

Date



Addendum A

Name of Client/Patient: _____
(Printed Legal Name)

Electronic Transmission of Information:

I, the undersigned, a citizen of _____ or _____, my designee(s), on
(City and State) (Printed Legal Name)
my behalf, agree to participate in technology-based consultation and other healthcare-related information exchanges with Marc Funk, LPC, LADC, a behavioral health care practitioner (“practitioner”).

This means that I authorize information related to my medical and behavioral health to be electronically transmitted in the form of images and data through an interactive video connection to and from the above-named practitioner, other persons involved in my health care, and the staff operating the consultation equipment.

Mobile Application:

- ___ It may also mean that my private health information may be transmitted from my practitioner’s mobile device to my own or from my device to that of my practitioner via an ‘application’ (abbreviated as “app”).
- ___ I understand that a variety of alternative methods of behavioral health care may be available to me, and that I may choose one or more of these at any time. My behavioral health care provider has explained the alternative to my satisfaction.

Equipment:

- ___ I represent that I am using my own equipment to communicate and not equipment owned by another, and specifically not using my employer’s computer or network. I am aware that any information I enter into an employer’s computer can be considered by the courts to belong to my employer and my privacy may thus be compromised.

Identification:

- ___ I understand that I will be informed of the identities of all parties present during the consultation or who have access to my personal health information and of the purpose for such individuals to have such access.

Telebehavioral Health Process:

- ___ My health care practitioner has explained how the telebehavioral health consultation(s) is performed and how it will be used for my treatment. My behavioral practitioner has also explained how the consultation(s) will differ from in-person services, including but not limited to emotional reactions that may be generated by the technology.

Additional Services:

4200 Perimeter Center Drive, Suite 245
Oklahoma City, OK 73112-2322
www.actts.org

Phone: (405) 243-7742
Fax: (405) 943-5850
mfunk@actts.org

CONFIDENTIAL



___ I understand that it is my duty to inform my practitioner of electronic interactions regarding my care that I may have with other health care providers.

Electronic Presence:

___ In brief, I understand that my practitioner will not be physically in my presence. Instead, we will see and hear each other electronically, or that other information such as information I enter into an “app” will be transmitted electronically to and from myself and my practitioner.

Limitations:

___ Regardless of the sophistication of today’s technology, some information my practitioner would ordinarily get in in-person consultation may not be available in teleconsultation. I understand that such missing information could in some situations make it more difficult for my practitioner to understand my problems and to help me get better. My practitioner will be unable to physically touch me or to render any emergency assistance if I experience a crisis.

Risks:

___ I understand that telebehavioral health is a new delivery method for professional services, in an area not yet fully validated by research, and may have potential risks, possibly including some that are not yet recognized.

___ Among the risks that are presently recognized is the possibility that the technology will fail before or during the consultation, that the transmitted information in any form will be unclear or inadequate for proper use in the consultation(s), and that the information will be intercepted by an unauthorized person or persons.

Release of Information:

___ I authorize the release of any information pertaining to me determined by my practitioner, my other health care practitioners or by my insurance carrier to be relevant to the consultation(s) or processing of insurance claims, including but not limited to my name, Social Security number, birth date, diagnosis, treatment plan and other clinical or medical record information.

Discontinuing Care:

___ I understand that at any time, the consultation(s) can be discontinued either by me or by my designee or by my health care practitioners.

___ I further understand that I do not have to answer any question that I feel is inappropriate or whose answer I do not wish persons present to hear; that any refusal to participate in the consultation(s) or use of technology will not affect my continued treatment and that no action will be taken against me.

___ I acknowledge, however, that diagnosis depends on information, and treatment depends on diagnosis, so if I withhold information, I assume the risk that a diagnosis might not be made or might be made incorrectly.

___ Were that to happen, my telehealth-based treatment might be less successful than it otherwise would be, or it could fail entirely.

Limits of Confidentiality:



___ I also understand that, under the law, and regardless of what form of communication I use in working with my practitioner, my practitioner may be required to report to the authorities information suggesting that I have engaged in behaviors that endanger others.

Alternatives:

___ The alternatives to the consultation(s) have been explained to me, including their risks and benefits, as well as the risks and benefits of doing without treatment. I understand that I can still pursue in-person consultations. I understand that the telebehavioral health consultation(s) does not necessarily eliminate my need to see a specialist in person, and I have received no guarantee as to the telebehavioral consultation's effectiveness.

Records:

___ I understand that my telebehavioral consultation(s) may be recorded and stored electronically as part of my medical records. I understand that consultations, test results, and disclosures will be held in confidence subject to state and/or federal law.

___ I understand that I am ordinarily guaranteed access to my records and that copies of records of consultation(s) are available to me on my written request.

___ I also understand, however, that if my practitioner, in the exercise of professional judgment, concludes that providing my records to me could threaten the safety of a human being, myself or another person, he or she may rightfully decline to provide them. If such a request is made and honored, I understand that I retain sole responsibility for the confidentiality of the records released to me and that I may have to pay a reasonable fee to get a copy.

___ I hereby authorize these disclosures to take place without prior written consent.

Compensation:

___ I understand that I am not entitled to royalties or to other forms of compensation for participation in any telebehavioral consultation(s) or other information exchange.

Contact Information:

___ I have received a copy of my practitioner's contact information, including his or her name, telephone number, voice mail number, business address, mailing address, and e-mail address. Specifically, this information is provided here:

Marc Funk, LPC, LADC
d.b.a. ACT Therapeutic Services
4200 Perimeter Center Drive, Suite 245
Oklahoma City, OK 73112
Cell Phone: (405) 243-7742
Fax: (405) 943-5850
E-Mail: mfunk@actt.org
Website: www.actts.org

___ I have also been provided with a list of local support services in case of an emergency. I am aware that my practitioner may contact the proper authorities and/or my designated, local contact person in case of an emergency.

Emergency Care:

4200 Perimeter Center Drive, Suite 245
Oklahoma City, OK 73112-2322
www.actts.org

Phone: (405) 243-7742
Fax: (405) 943-5850
mfunk@actts.org

CONFIDENTIAL



___ I acknowledge, however, that if I am facing or if I think I may be facing an emergency situation that could result in harm to me or to another person; I am not to seek a telebehavioral consultation. Instead, I agree to seek care immediately through my own local health care practitioner or at the nearest hospital emergency department or by calling 9-1-1.

___ These are the names and telephone numbers of my local emergency contacts (including local physician; crisis hotline; trusted family, friend, or adviser).

_____	_____
Name	Telephone Number
_____	_____
Name	Telephone Number
_____	_____
Name	Telephone Number

Release of Liability:

___ I unconditionally release and discharge Marc Funk, LPC, LADC d.b.a. ACT Therapeutic Services, its affiliates, agents, and employees from any liability in connection with my participation in the remote consultation(s).

Final Agreement:

___ I have read this document carefully and fully understand the benefits and risks. I have had the opportunity to ask any questions I have and have received satisfactory answers.

___ I have also received, read, and understand **The Client Handbook and The Notice of Privacy Practices made available to me (on my practitioner's website: www.actts.org)** at the time I registered for telehealth services with my practitioner.

___ With this knowledge, I voluntarily consent to participate in the telebehavioral consultation(s), including but not limited to any care, treatment, and services deemed necessary and advisable, under the terms described herein.

Client Name

Date

Marc Funk, LPC LADC

Counselor Name

Date