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Telemental Health Informed Consent for Treatment

Explanation of Telehealth and its Advantages and Disadvantages

Telemental health is the delivery of behavioral health services using interactive technologies (audio, video or other electronic communications) between a provider and a client that are not in the same physical location. The interactive technologies used in telemental health incorporate network and software security protocols to protect the confidentiality of 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. Electronic systems used will incorporate network and software security protocols to protect the privacy and security of health information and imaging data and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption.

By signing this document you agree to the statements below:

• Janet M Roberts, PhD, my provider, has 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. In brief, I (the “client”) 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 my practitioner and I. 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.

• I understand that telehealth consultation is a relatively new form of treatment, in an area not yet fully validated by research, and that they 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. In rare instances, security protocols could fail, causing a breach of privacy of personal health information.

• I understand that a variety of alternative methods of mental health care may be available to me, and that I may choose one or more of these at any time. My mental health care provider has explained the alternatives to my satisfaction, 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 telehealth consultation(s) does not necessarily eliminate my need to see a specialist in person, and I have received no guarantee as to the telehealth consultation’s effectiveness.

• I may decline any telehealth services at any time without jeopardizing my access to future care, services or benefits.

Privacy, Confidentiality and Record Keeping

• 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. 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.

• Insurance companies, individuals/organizations authorized by the client, and others permitted by law may have access to my records or communications. I authorize the release of any information required by law or for insurance claims (only if billing through insurance). This information includes but is not limited to my name, social security number, insurance group and member number, birth date, diagnosis, treatment plan and other clinical or medical record information.

• 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.

• My communication with my behavioral health practitioner will be stored in compliance with HIPAA regulations secured electronic medical record files. I understand that my telehealth consultation(s) may be recorded and stored electronically as part of my medical records. The practitioner will inform me if this is to occur and the reasons for this being necessary.

• 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 medical records and that copies of records of consultation(s) are available to me on my written request. 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 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), she may rightfully decline to provide them.

• Additionally, I understand that my records may be used for telehealth program evaluation, education, and research and that I will not be personally identified if such a use occurs. I hereby authorize these disclosures to take place without prior written consent. I understand that I am not entitled to royalties or to other forms of compensation for participation in any telehealth consultation(s) or information exchange.

Client Responsibility for Privacy Protection

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

• It is my responsibility to maintain privacy on the client end of communication.

• I will use my own equipment to communicate and not equipment owned by another. 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.

• I will take the following precautions to ensure that my communications are directed only to my practitioner or other designated individuals: Double check email addresses; double check phone numbers, double check to whom email is sent (reply vs reply all).

• I understand that I do not have to answer any question I feel is inappropriate or whose answer I do not wish persons present to hear. Any refusal to participate in the consultation(s) or use of technology will not affect my continued treatment and no action will be taken against me. I acknowledge, however, that effective treatment depends on accurate information, so if I withhold information my telehealth-based treatment might be less successful than it otherwise would be, or it could fail entirely.

Handling Service Disruptions

• In the event of disruption of services, or for routine or administrative reasons, it may be necessary to communicate by other means. I have the contact information for my practitioner and have provided her with alternative means to contact me. My practitioner may utilize alternative means of communication when video connections fail or phone line access is disrupted.

• My practitioner will respond to communications and routine messages within 48 hours on business days or on the next business day following weekends, holidays, or vacations.

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

Handling Crisis Situations and/or Need for Face to Face Contact with a Clinician

• If a need for direct, face-to-face services arises it is my responsibility to contact my provider to request a face-to-face appointment. If that is not geographically practical or if he or she is not available I will contact behavioral health practitioners in my area or my primary care provider. I understand that an opening may not be immediately available with any of these providers.

• 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 agree NOT to seek a telehealth consultation. Instead I agree to seek care immediately through a local health care practitioner, from a crisis organization such as Colorado Crisis Services (<http://coloradocrisisservices.org/about/> Phone: (844) 493-8255 or Text: 38255), from the nearest hospital emergency department, or by calling 911.

• I have identified local support services to contact in case of an emergency

• I am aware that my practitioner may contact the proper authorities and/or my designated local contact person(s) in case of an emergency.

• 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.

Planning for Emergencies:

I agree to contact the following people/agencies in the case of an emergency, and also authorize my provider to do so on my behalf should she believe it necessary to protect me from harm:

911 or hospital emergency room (ER)

Local physician –Telephone number

Crisis Services Hotline –Telephone number

Emergency Mental Health Services (ER or crisis center) –Telephone number

Family member/close friend /advisor–Telephone number

Family member/close friend /advisor–Telephone number

Family member/close friend /advisor–Telephone number

Names of local behavioral health providers who can be contacted if I need face-to-face care that my provider is not able to provide:

Name, Business Name, Phone Number

Agreement to Initiate Telehealth Treatment

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

• With this knowledge, I voluntarily consent to participate in the telehealth videoconference consultation(s), including but not limited to any care, treatment, and services deemed necessary and advisable under the terms described herein. 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. It may also mean that details of my private health information and medical history 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”). This service is provided by technology (included but not limited to video, phone, text and email) and may involve direct face to face communication.

• I unconditionally release and discharge Janet M Roberts, PhD, her affiliates, agents and employees; and any other organization involved in the remote consultation(s) from any liability in connection with my participation with telehealth remote consultations.

• 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.

• I understand and agree to all of the information in this document.

Please print client name above.

Client’s or Responsible Party’s Signature Date

Feel free to ask questions after reviewing this form. I look forward to working with you!