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New Day Psychology, LLC
Vered Dor, PsyD
Telebehavioral Health Informed Consent

Name: _____ Date of Birth: _____

Today's Date: _____

Introduction of Telebehavioral Health:

As a client or patient receiving behavioral services through telebehavioral health technologies, I understand:

1 Telebehavioral health is the delivery of behavioral health services using interactive technologies (use of audio, video or other electronic communications) between a practitioner and a client/patient who are not in the same physical location.

2 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:

3 *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.*

Benefits & Limitations:

4 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.

Technology Requirements:

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

Exchange of Information:

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

7 *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:

8 If a need for direct, in-person services arises, it is my responsibility to contact my behavioral practitioner's office 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.

Self-Termination:

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

Risks of Technology:

10 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.

Client Initials: _____ I give my consent to section 1-10.

Modification Plan:

11 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:

12 In the event of disruption of service, or for routine or administrative reasons, it may be necessary to communicate by other means, such as, but not limited to phone, text messaging, messenger, ECT.

Practitioner Communication:

13 My practitioner will respond to communications and routine messages within 2 business days.

Client Communication:

14 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.

15 I will take the following precautions to ensure that my communications are directed only to my psychologist or other designated individuals:

- _____
- _____

Storage:

16 My communication exchanged with my practitioner will be stored in a secured HIPPA compliant system called _____**Zoom or Doxy.me**_____

Laws & Standards:

17 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:

_____ I give my consent to sections 1-17 **(name and signature)**

Client Printed Name

_____

Signature of Client or Legal Guardian **Date** _____

_____

Printed Name of Practitioner

_____

Signature of Practitioner Date **Date** _____

_____

Addendum Behavior Health Consent

Name of Client: _____ Date of Birth: _____

Please fill the checkboxes:

Mobile Application:

- ☐ It may 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 other 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 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 behavior 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.

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 provide the most effective intervention(s). Further, this missing information is of greatest potential detriment in the event of significant emotional 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.
- ☐ *In rare instances, security protocols could fail, causing a breach of privacy of personal health information.*

Release of Information:

□ I authorize the release of any information pertaining to me determined by my practitioner, 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 practitioner.
- □ 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 if I am assessed to be of imminent risk of danger to myself or 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 copy(ies)/recording(s) of telehealth consultation(s) are not saved and are therefore not available to me.

Contact Information:

- □ I have received a copy of my practitioner's contact information, including his or her name, telephone number, business address, mailing address, and e-mail address.
- □ 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:

□ I acknowledge 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; Telehealth IS NOT an appropriate vehicle for care in this situation; and I am not to seek a telebehavioral consultation. Instead, I agree to seek care immediately through a local crisis service, health care practitioner, at the nearest hospital emergency department or by calling 911.

□ I Agree to all sections above.

Name:_____ Signature:_____

☐ These are the names and telephone numbers of my local emergency contacts Including local physician; crisis hotline; trusted family, or friend.

Name	Relationship	Telephone
Name	Relationship	Telephone
Name	Relationship	Telephone
Name	Relationship	Telephone

Release of Liability:

☐ I unconditionally release and discharge **New Day Psychology, LLC** and its affiliates from any liability in connection with my participation in the remote consultation(s) / therapy sessions.

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.

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

☐ As a legal guardian, with this knowledge, I voluntarily consent to the participation of my MINOR CHILD and other family members (as clinically indicated and agreed upon) in telebehavioral consultation(s) and including and not limited to any care, treatment, and services deemed necessary and advisable, under terms described herein.

Client Printed Name

_____

Signature of Client or Legal Guardian **Date** _____

_____

Printed Name of Practitioner/Witness

_____

Signature of Practitioner/Witness **Date** _____

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