Affirmative Transformation Services, LLC

CLIENT INFORMATION AND INFORMED CONSENT FOR TELEMENTAL HEALTH TREATMENT

Telemental health services involve the use of electronic communications (telephone, written, text, email, video conference, etc.) to enable therapists to provide services to individuals who may otherwise not have adequate access to care. Telemental health may be used for services such as individual, couples, or family therapy, follow-ups, and trainings/education in a group setting, as well as supervision and consultation on cases. Telemental health is a therapeutic approach that has evolved tremendously over the years in the delivery of services, but there are some limitations compared with seeing a therapist in person. These limitations can be addressed and are minor depending on the needs of the client and the care with which the technology (cell phone, computer, etc.) is utilized. It is important that both the client and the therapist are located in a private place during their sessions, and that the security of their technology is up-to-date with appropriate security protection.

Additional Points for Client Understanding:

- I understand that my identification has to be verified and must be done so in the form of a picture identification displayed at the beginning of the session to the therapist.
- I understand that if I change the location in which I am receiving telemental health services, I will notify the therapist ahead of time so that arrangements can be made.
- I understand that telemental health services are completely voluntary and that I can choose not to do it or not to answer questions at any time.
- I understand that none of the telemental health sessions will be recorded or photographed without my written permission.
- I understand that the laws that protect the privacy and the confidentiality of client information also apply to telemental health and that no information obtained in the use of telemental health that identifies me will be disclosed to other entities without my consent.
- I understand that because this is a technologically based method, it may sometimes be necessary for a technician to assist with the equipment. Such technicians will keep any information confidential.
- I understand that telemental health is performed over a secure communication system that is almost impossible for anyone else to access. However, because there is still a possibility of a breach, I accept the very rare risk that this could affect confidentiality.
- My therapist has explained to me how video conferencing technology and telephone procedures will be used. I understand that any telemental Health sessions will not be the same as an in-person session because I will not be in the same room as my therapist.
- I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my therapist or I may discontinue the telemental sessions at any time if it is felt that the videoconferencing, text, email, or telephone connections are not adequate for the

situation.

- I understand that my demographic information may be shared with other individuals for scheduling and billing purposes.
- I understand that I may experience benefits from the use of telemental health in my care, but that no results can be guaranteed or assured.
- I understand that if there is an emergency during a telemental health session, then my therapist will call emergency services, my designated person, and/or my emergency contacts.
- I understand that if the video conferencing or telephone connection drops while I am in a session, I will have an additional phone line available to contact my therapist, or I will make further plans with my therapist ahead of time for re-contact.
- I understand that I am required to provide a safety plan that is shared with my therapist in case of an emergency (see Telemental Health Safety form Addendum)
- I understand that telemental health-based services may not be appropriate for everyone seeking therapy. I also understand that if my therapist believes I would be better served by another form of therapeutic services (e.g., face-to-face services), I will be referred to a practitioner who can provide such services in my area.
- I understand that this form is signed in addition to the Information, Authorization, and Consent to Treatment document and that all policies and procedures within the Information, Authorization, and Consent to Treatment document apply to telemental health services.
- I understand I may be requested to install applications specific to treatment onto my phone, tablet, or computer device. Some applications specifically interact via phone/tablet, device, etc. and have the capability to report activity, GPS location, etc.
- I understand I have the right to withhold or withdraw this consent at any time. However, if I do so, this may require Affirmative Transformation Services or my therapist to provide referrals to other treatment providers if face-to-face services are not an option based on geography and/or circumstance.
- I understand the laws that protect the confidentiality of my personal health information also apply to telemental health, as do the limitations to that confidentiality discussed in the Information, Authorization, and Consent to Treatment document. I also understand that the dissemination of any personally identifiable images or information from the telemental health interaction will not be shared without my written consent.
- I understand that an electronic signature of the forms provided by Affirmative Transformation Services, LLC, or my therapist serves as the equivalent to a traditional physical signature.

Instructions for Video Conferencing Software:

Affirmative Transformation Services uses the telemental health platform associated with Simple Practice. When your appointment is scheduled, a link will be provided in the confirmation email or text through the Simple Practice Client Portal. Simply click on the link at your scheduled appointment time to connect with your therapist.

Consent:

I consent to engage in telemental health as part of my treatment with Affirmative Transformation Services, LLC, and my therapist. I understand that “telemental health” includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of personal health information, and education using interactive audio, video, or data communications. I understand the information provided above regarding telemental health. I have discussed

the consent with my therapist or assistant as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemental health in my care.

_____
Signature of Patient or Personal Representative

_____
Printed Name of Patient or Personal Representative

Date _____

Description of Personal Representative's
Authority:_____

Affirmative Transformation Services, LLC

Providing a Positive Agent for Growth

TELEMENTAL HEALTH SAFETY PLAN ADDENDUM

Client Name (first and last): _____

Physical Address of Client during telemental health sessions:

Street: _____

City: _____ County: _____ State: _____ Zip: _____

Client's Phone Number: _____ Alternative Phone Number: _____

(It is required that the client provide their location at each session when using, and it may be required that the client be at that same location for each session for the purposes of insurance payments.)

Designated Contact: _____

Relationship: _____ Phone Number: _____

City/State: _____

Emergency Contact (1): _____

Relationship: _____ Phone Number: _____

City/State: _____

Emergency Contact (2): _____

Relationship: _____ Phone Number: _____

City/State: _____

Local Hospital (local to telemental health location of client): _____

Phone Number: _____

- I have provided a designated person, along with two emergency contact numbers and the number to the local hospital or another facility as deemed appropriate.
- If there is an emergency during a session, my therapist has permission to contact my emergency contacts and the local hospital.
- I have provided a working telephone number to reach me if the video conferencing connection fails during a session.
- My therapist has provided me with a contact number. If connections fail and my counselor does not call me back within 5 minutes, then I will call my therapist.

Signatures:

_____ _____

Client or Representative Date