CORAL GABLES Counseling CENTER

Telepsychology Treatment Consent Form

Introduction:

Telepsychology is the provision of non-face-to-face psychological services using distance communication technologies such as telephone, e-mail, chat and interactive video conferencing services including, but not limited to, Skype, FaceTime, Text Messages, iMessage and WhatsApp. These services enable a psychologist and/or his associates to provide treatment to their patients from a distant location. I understand that this consultation will not be the same as an in-person psychologist-patient consultation. I am receiving this treatment in lieu of an in-person visit.

During the telepsychology consultation:

a. Details of my medical history, current medications, and results of medical tests may be discussed.
b. Non-medical personnel may be present to assist in the operation of video conferencing equipment, as needed.

Potential Risks:

The risks associated with telepsychology include, but are not limited to:

- Information transmitted may not be sufficient to allow for appropriate medical decision making by the clinician.
- The clinician may not be able to provide the type of treatment needed using interactive electronic equipment nor provide for or arrange for emergency care that I may require.
- Delays in medical evaluation and treatment may occur due to deficiencies or failure of the equipment.
- Security protocols can fail, causing a breach of privacy of my protected health information ("PHI").
- The clinician's limited access to all of the information that may be available in your patient file (i.e. patient psychology notes and records, books, etc.) may impact his psychological treatment.

My Rights:

- I understand that the laws that protect the privacy and confidentiality of my PHI also apply to telepsychology.
- I understand that some of the video conferencing services and technology used by The clinician and/or his associates may use encryption technology to prevent the unauthorized access to my PHI.

- I have the right to withhold or withdraw my consent to the use of these telepsychology services during the course of my treatment at any time. I understand that my withdrawal of consent will not affect any future treatment.
- I understand that The clinician has the right to withhold or withdraw consent for the use of telepsychology during the course of my treatment.
- I understand that the rules and regulations which apply to the practice of Psychology in the state of Florida also apply to telepsychology.
- My psychologist and I will regularly reassess the appropriateness of continuing to deliver services to me through the use of technology.

My Responsibilities:

- I will not use any type of video recording device during any portion of our telepsychology sessions without first obtaining written consent from The clinician and/or his associates. I understand that The clinician and/or his associates will not use any type of video recording device during any portion of our telepsychology sessions without first obtaining my written consent with the exception of handwritten notes for purposes of providing treatment.
- I will inform The clinician if any other person can hear or see any portion of our session as soon as it is reasonably discoverable. It is my responsibility to create a safe and comfortable environment and to ensure that I am in a private area where the session can't be easily overhead by passersby. The clinician will inform me if any other person can hear or see any portion of our session as soon as it is reasonably discoverable.
- I understand that I, not The clinician and/or his associates, am responsible for the configuration of any electronic equipment used on my computer for our telepsychology sessions. I understand that it is my responsibility to ensure the proper functioning of all electronic equipment before my session begins.
- I will provide The clinician with the names and contact information of a designated local psychiatrist of my choice, as well as, a local psychiatric receiving hospital, that can be contacted to provide me with treatment should an emergency arise unexpectedly. In the event of an emergency, The clinician has the authority under Florida and Federal law[1] to break our confidentiality agreement to the extent necessary, to provide life-saving information or to reduce the risk of harm to myself or to a third party.

[1] The Privacy Regulations of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

- I understand that I must be a resident of the state of Florida, and that I must be physically present in the state of Florida during my sessions with the clinician **or** an exemption for the temporary provision of telepsychology services within a foreign state that I am visiting must exist in order to receive telepsychology services from the clinician.

Payment of Fees:
A non-refundable pre-payment fee of **$**_____ must be submitted in order for the clinician to provide the 60-minute telepsychology session to me, the patient. The aforementioned payment can be paid using a personal check, cashier's check, or money order made payable to "Coral Gables Counseling Center". Alternatively, payments can be made using a credit card or charge card that is generally accepted and valid throughout the United States and its territories.

Security:
The interactive video conference services listed above, which are used in telepsychology, are known to incorporate network and software security protocols to protect the confidentiality of information and audio/visual data. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption and publication. I fully understand that neither Skype nor FaceTime is a guaranteed format for client confidentiality. I understand that the clinician offers distance counseling via phone sessions and that telephone is not HIPPA protected. I understand that I have the option to choose which method(s) I prefer.

Technology Failure:
I do understand that in the event of a technology failure during a phone or visual telecommunication session immediate steps will be taken by The clinician and/or his staff to reconnect. Contact via email is the first backup step to failed phone and visual telecommunication reconnection. The clinician and/or his staff will repeatedly attempt to use these methods to contact me through the remaining session time (and I will do the same, as well). If necessary, regular US Postal Service mail is a backup to visual, phone or email failure. I will confirm receipt of successful contact. The compromised appointment will be rescheduled and, unless other arrangements are made, will be billed at the full rate.

Miscellaneous:

- I understand that I must provide 24 hour notice of cancellation of our telepsychology session in accordance with the Coral Gables Counseling Center policy.
- All paperwork must be completed, signed and returned to our office a minimum of 24 hours prior to the session along with a copy of a valid form of photo identification.
- If you have any urgent concerns, please seek medical attention immediately.
- I agree that neither the clinician nor the Coral Gables Counseling Center shall be responsible for any inability of Patient to contact The clinician except as such failure may have been caused by the negligence or intentional misconduct of The clinician or the Coral Gables Counseling Center.
- This document does not replace other agreements, contracts, or documentation of informed consent.
- By signing this consent form you agree that you have received a copy of this consent form.

Patient Consent for the Use of Telepsychology:

I _____ have read and understand the information provided above regarding telepsychology, have discussed any concerns with the clinician and his associates, and any and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telepsychology in my treatment and authorize the clinician to use telemedicine in the course of my diagnosis and treatment.

____I give my consent to use iMessage and WhatsApp for my distance counseling.

____I give my consent to use FaceTime and Skype for my distance counseling.

____I prefer to only engage in a visual communication that is HIPPA compliant.

____I give my consent to use the telephone for my distance counseling.

Patient Signature: _____ **Date**: _____

Name: _____

(signature page continues next page)

Email address: _____

Home address: _____

City, State, Zip: _____

Phone #: _____

Alternate #: _____

Facetime/iMessage Contact: _____

Skype Username: _____

WhatsApp Contact: _____

<u>Psychiatrist Contact Info (if applicable):</u>

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____

<u>Psychiatric Receiving Hospital (if living/travelling outside of Miami, FL):</u>

Name: _____

Home address: _____

City, State, Zip: _____

Phone:_____