Informed Consent for Telemental-health Services at The Olson Marriage and Family Therapy Clinic

Introduction

Telemental health involves the use of electronic communications to enable health care providers to share individual patient therapeutic information, for the purpose of improving patient care. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient therapeutic records
- Therapeutic images
- Live two-way audio and video
- Output data from therapeutic devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption. In other words, Zoom Business states that their system is HIPAA Compliant.

Phone sessions are however not HIPAA compliant, due to the nature of phones. Your student therapist will do everything they can to maintain your confidentiality in telehealth sessions but we cannot promise full confidentiality due to conducting these sessions from home offices during the crisis. By agreeing to either phone or Zoom video session, you agree to assume the risk of limited confidentiality of the session content and personal protected health information.

Expected Benefits:

- Improved access to therapeutic care by enabling a patient to remain in his/her/their remote site while the therapist will be in their practice location.
- More efficient therapeutic evaluation and mental health management.
- Obtaining expertise of a therapist from a distance.
- To continue patient care in cases of public health crises.

Possible Risks:

There are potential risks associated with the use of ***any*** telemental health device and/or services. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate therapeutic decision making by the therapist and supervisor(s).
- Delays in therapeutic evaluation and treatment could occur due to deficiencies or failures of the equipment.
- In very rare instances, security protocols could fail, causing a breach of privacy of personal therapeutic information.

Your therapist will contact you with an appointment date and time via email. Your name, date and time of appointment is considered Protected Health Information (PHI). Due to the risk inherent in HIPAA compliance with the use of any telemental health or technology devices, please consider the following:

Informed Consent for Telemental-health Services at The Olson Marriage and Family Therapy Clinic

The 2013 HHS HIPPA Omnibus Rule: "If individuals are notified of the risks and still prefer unencrypted email, **the individual has the right to receive protected health information in that way**, and covered entities are not responsible for unauthorized access of PHI while in transmission to the individual, based on the individuals request. Further, covered entities are not responsible for safeguarding information once delivered to the individual" (U.S. Department of Health and Human Services, 2013).

You should also be aware that any emails we receive from you and any responses that we send to you become a part of your legal record.

With this in mind, please initial each of the following statements, demonstrating understanding and agreement.

____ I understand the risks of receiving an email for my appointment through Zoom and/or KASA (medical records system) and I still prefer to receive these.

____ I understand the risks of receiving and communicating with my therapist about appointment times via email and I still prefer to receive these.

____ I understand that all electronic communication is a part of my legal medical record.

_____ I understand that I have to be physically located in the State of Iowa at the time of my session. If I am not I understand I must reschedule the session.

_____ I also understand that the Olson MFT Clinic is utilizing a new suicidality protocol during this time while doing telehealth sessions. I understand I will be asked EVERY session, before starting the session, if I have any suicidal thoughts, ideation, plan or intention. I understand if I say "yes" to anything more than passive ideation, I will be required to call Foundation 2 crisis line so that I can be fully assessed for safety. I understand I cannot continue sessions without this confirmation of safety. I understand if I tell my therapist I have intentions or plans of suicide my therapist will call mobile crisis and/or police to come to me.

Tips for a Successful Telemental health Video Visit

- Check your internet connection
- Make sure your audio and video are working
- Find a quiet, private location if possible
- Check your lighting
- Write down problems and questions ahead of time
- Dress appropriately for the visit
- Consider using headphones
- Consider using a computer instead of your smart phone
- Have easy access on your computer to any pictures or therapeutic reports you want to share with the therapist.
- Have a trusted assistant to help you with the technology, if necessary

Scheduling your Telemental health Appointment

- Your therapist will contact you with an available appointment date and time via email
- An email will be sent with the providers room link for access to your telemental health appointment

Informed Consent for Telemental-health Services at The Olson Marriage and Family Therapy Clinic

Logging In to your Telemental health Visit

- You ***must use*** Chrome/Firefox/or Safari. These browsers allow for your microphone and camera to work properly.
- You will Enter the web address with the correct providers name as listed below: https://zoom.us/
- Please ensure your microphone and webcam are enabled and functioning upon logging in
- Enter your name and click "Check In"
- You will appear in the providers queue as "Arrived" and your appointment will begin promptly
- For more assistance please watch this video:

  https://support.zoom.us/hc/en-us/sections/201740096-Training

Informed Consent for Telemental health Services Continued:

1. PURPOSE: The purpose of this form is to obtain your consent to participate in a telemental health session in connection with the following procedure(s) and/or service(s):

- Marriage and Family Therapy
- Letter of Support Writing

2. THERAPEUTIC INFORMATION & RECORDS: All existing laws regarding your access to therapeutic information and copies of your therapeutic records apply to this telemental health session. Please note, none of the telecommunications are recorded and stored. Additionally, dissemination of any patient-identifiable images or information for this telemental health interaction to researchers or other entities shall not occur without your consent.

3. CONFIDENTIALITY: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemental health session, and all existing confidentiality protections under federal and Iowa state law apply to information disclosed during this telemental health session.

4. RIGHTS: You may withhold or withdraw consent to the telemental health session at any time without affecting your right to future care or treatment.

5. PAYMENT OF SERVICES: The Olson MFT Clinic is not charging fees during the time limited to Telehealth sessions only. You agree upon return to face to face sessions, therapist and client will discuss and reevaluate for a session fee, based on Olson regular terms and policies.

6. RISKS, CONSEQUENCES & BENEFITS: You have been advised of all the potential risks, consequences and benefits of telemental health. Your mental health practitioner has discussed with you the information provided above. You have had the opportunity to ask questions about the information presented on this form and the telemental health session. All your questions have been answered, and you understand the written information provided above.

Informed Consent for Telemental-health Services at The Olson Marriage and Family Therapy Clinic

I agree to participate in a telemental health sessions for the procedure(s) described above.

Client Legal Name (print):

_____

Client Preferred Name, if different than above (please print):

Client Signature: _____DATE:_____

****

Client Legal Name (print):

_____

Client Preferred Name, if different than above (please print):

Client Signature: _____DATE:_____

****

Parent/Guardian Legal Name (print):

_____

Parent/Guardian Preferred Name, if different than above (please print):

P/G Signature: _____DATE:_____