Informed Consent for Tele-behavioral Health Services

The following information is provided to clients who are seeking tele-behavioral health services. This document covers your rights, risks and benefits associated with receiving services, my policies, and your authorization. Please read this document carefully and note any questions you would like to discuss.

Client's Rights

- You have the right to decide to end tele-behavioral health services at any time without prejudice.
- You have the right to ask any questions about procedures used during tele-behavioral health services. If you wish, I will explain my method of psychotherapy or other counseling practices used with tele-behavioral health services.
- You have the right to refuse the use of any therapeutic technique. I will inform you if I intend to use any unusual procedures and explain any risks involved.
- Tele-behavioral health services are not appropriate for all clients. Generally, those who are experiencing suicidal ideation or altered mental status are not appropriate for tele-behavioral health services. Should tele-behavioral health services not be a good fit for you, I will assist you in finding alternative options.

Benefits and Risks

Tele-behavioral health refers to psychotherapy/counseling services that occur via phone, email, or synchronous video conferencing. All of our interactions will fall under this term for online behavioral health counseling sessions. When using technology there is always the risk of security issues, as well as technical issues (phone not charged, computer or software not working, etc.). We will develop an individualized plan for how best to address technical issues that may arise and will take steps to facilitate the security of interactions with your provider. In addition to the identified risks, there are several benefits that come from using technology. For instance, it allows providers to connect with people who may otherwise not be able to access services, there is an opportunity for more flexibility in scheduling, and convenience in being able to connect from a space of your choosing.

FourPoints Health can assure confidentiality of electronic communications on our end of the service. Your provider will invite you to a confidential online meeting through a HIPPA approved and confidential platform. However, we cannot guarantee your privacy on your end of the communication. In order to protect your confidentiality and to facilitate the security of your information as much as possible, here is a list of recommendations:

- Engage in sessions in a private location where you cannot be heard by others
- Use a private phone
- Do not record any sessions
- Password protect any technology you will be interacting with your therapist on
- Always log out or hang up once sessions are complete

- To avoid others knowing we have connected, your provider will be contacting you from a blocked number.

Emergency Management Plan

FourPoints Health does not provide emergency services. As a precaution, please identify one (1) nearby emergency hospital below. In addition, you will need to provide information for an emergency contact person. These all need to be filled out to participate in tele-behavioral health services.

Hospital Name:____

Hospital Address:____

Hospital Phone:____

Emergency Contact Name:____

Emergency Contact Number:____

My location during my tele-behavioral health session, in case of an emergency so that my provider can send medical help to me if necessary:

____

Contacting Your Provider

Telephone or encrypted email are the main forms of contact that will be used outside of the consultation and sessions.

Payment for Services

I agree to call the clinic receptionist and pay my designated co-pay prior to attending my counseling session.

Authorization for Treatment

I,______________________________________(name of client), have read, understand and authorize evaluation and treatment from FourPoints Behavioral Health. I acknowledge that I may request a copy of this informed consent agreement. It is agreed that either of us may discontinue treatment at any time.

Signature of client: ____________________________________ Date: _______________________