



Murray Counseling, PLLC
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Telemental Health Informed Consent

As a client receiving behavioral services through telehealth methods, I understand:

Telemental health is the delivery of behavioral health services using interactive technologies (audio, video or other electronic communications) between a provider and a client that are not in the same physical location. The interactive technologies used in Telemental health incorporate network and software security protocols to protect the confidentiality of 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. 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.

1. This service is provided by technology (included but not limited to video, phone, text, and email) and may involve direct face to face communication. There are benefits and limitations to this service. I will need access to, and familiarity with, the appropriate technology in order to participate in the service provided. The exchange of information will not be direct and any paperwork exchanged will likely be provided through electronic means or through postal delivery.
2. If a need for direct, face to face services arises, it is my responsibility to contact therapists in my area or to contact my therapist's office for a face to face appointment or my primary care provider if my therapist is unavailable. I understand that an opening may not be immediately available in either office.
3. I may decline any telehealth services at any time without jeopardizing my access to future care, services or benefits.
4. 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. My therapist 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.

5. In emergencies, in the event of disruption of services, or for routine or administrative reasons, it may be necessary to communicate by other means (cell phone, land line, email):

- a. In emergency situations: _____
- b. Service disruption: _____
- c. For other communication: _____

6. My therapist may utilize alternative means of communication in the following circumstances: video connections fail or phone line access is disrupted.

7. 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.

8. My communication with my therapist will be stored in the following manner: In compliance with HIPAA regulations in secured file cabinets and/or secured electronic medical record files.

9. 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.

Furthermore, I agree to participate in technology-based consultation and other health-care related information exchanges with Laurie L. Murray, therapist at Murray Counseling. This means that I authorize information related to my medical and behavioral health to be electronically transmitted in the form of images and data through an interactive video connection to and from the above-named.

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. My therapist has explained how the telehealth consultation(s) is performed and how it will be used for my treatment. My therapist 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.

In brief, I understand that my therapist will not be physically in my presence. Instead, we will see and hear each other electronically, or will be transmitted

electronically to and from my practitioner and I. 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 help me get better. My therapist will not be able to render any emergency assistance if I experience a crisis.

I understand that telehealth consultation(s) are a new form of treatment, in an area not yet fully validated by research, and that they 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. I understand that a physical examination may be performed by individuals at my location at the request of the consulting practitioner. I authorize the release of any information pertaining to me determined by my therapist, my other health care practitioners or by my insurance carrier to be relevant to the consultation(s) or processing of insurance claims, including but limited to my name, Social Security number, birth date, diagnosis, treatment plan and other clinical or medical record information.

I understand that at any time, the consultation(s) can be discontinued either by me or by my therapist. I further understand that I do not have to answer any question 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. I also understand that, under the law and regardless of what form of communication I use in working with my therapist, my therapist may be required to report to the authorities information suggesting that I will engage in behaviors that endanger myself or others. 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 telehealth consultation(s) does not necessarily eliminate my need to see a specialist in person, and I have received no guarantee as to the effectiveness of the telehealth consultation.

I understand that consultations, test results, and disclosures will be held in confidence subject to state and/or federal law. I understand that I am ordinarily

guaranteed access to my medical records and that copies of records of consultation(s) are available to me on my written request. I also understand, however, that if my therapist, in the exercise of professional judgment, concludes that providing my records to me could threaten the safety of a human being, myself or another person, he/she may rightfully decline to provide them.

I have received a copy of my therapist's contact information, including her name, telephone number, business address, mailing address, and email address. I have also been provided with a list of local support services in case of an emergency. I am aware that my therapist may contact the proper authorities and/or my designated local contact person in case of an emergency. I acknowledge, however, that 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; I am not to seek a telehealth consultation. Instead I agree to seek care immediately through my own local health care practitioner or at the nearest hospital emergency department or by calling 911. These are the names and telephone numbers of my local emergency contacts (including local physician; crisis hotline; trusted family, friend or adviser).

Name - Relationship -Telephone number

Name - Relationship -Telephone number

Name - Relationship -Telephone number

Name - Relationship -Telephone number

I unconditionally release and discharge from any liability in connection with my participation with telehealth remote consultations. I have read this document carefully and fully understand the benefits and risks. I have had the opportunity to ask questions I have and received satisfactory answers. With this knowledge, I voluntarily consent to participate in the telehealth videoconference consultation(s), including but not limited to any care, treatment, and services deemed necessary and advisable, under the terms described herein.

Print name of client

Signature of client

Date

Parent or Legal Guardian (if client is a minor)

Date