

## Informed Consent for Telemedicine

This Agreement is intended to provide (name of client) \_\_\_\_\_ (herein "Client") with important information regarding the practices, policies and procedures of my therapist with regard to providing therapeutic treatment through the use of Telehealth.

### **Telehealth Defined**

In California, "telehealth" is defined as a method to deliver health care services using information and communication technologies to facilitate the diagnosis, consultation, treatment, and care management while the patient and provider are at two different sites. The two most common modes of telehealth for psychotherapy are via 1) live video conferencing either through a personal computer with a webcam or a mobile communications device with two-way camera capability, and 2) telephone. Business and Professions Code Section 2290.5 requires the therapist to 1) inform the client about the use of telehealth; 2) obtain from the client verbal or written consent for the use of telehealth as an acceptable mode of delivering psychotherapy services; and 3) document the consent obtained by the client in the client's treatment record. The law does not currently allow Telehealth across state lines.

### **Risks and Limitations of Treatment via Telehealth**

There are potential risks and limitations of receiving treatment via telehealth. Potential risks and limitations may include:

1. Technical failures by equipment being used. Thus, a session could be cut short or be interrupted due to technical failures.
2. Interruption by unauthorized persons. The Patient should be aware that there are situations that could compromise the confidentiality of the therapeutic conversation. For example, someone may listen in on the conversation; or, be in the same room as the patient but outside the view of the camera. Thus, the patient should feel comfortable in the environment where they are receiving services and in setting appropriate boundaries to ensure his or her own privacy.
3. Decreased availability of the therapist in the event of a crisis. (See section on Relevant Resources Information)

### **Disclosure of License**

The law requires Therapist to provide Client with his or her license number and the type of license.

Therapist Name: \_\_\_\_\_

Type of license & license number: \_\_\_\_\_

Clinical Supervisor: Phyllis Vokey Long, LMFT #43695

### **Platform for Telehealth Sessions**

Therapists will use doxy.me, LLC, a telemedicine service provider. doxy.me ensures the implementation of appropriate safeguards for certain individually identifiable Protected Health Information. They assure that their technology appropriates physical, technical and administrative safeguards and complies with the Security Rule with respect to e PHI. They use

128-bit Encryption and they are HIPAA Compliant. Callers remain anonymous, no record of PHI is kept and any data recorded during a call is permanently destroyed at the end of the call. Your therapist will supply the link to the waiting room once an appointment has been established.

Alternate platforms in times of crisis or emergency may include: telephone, Facetime, Facebook Messenger Chat, Zoom for Business.

### **Requirements for Each Telehealth Session**

1. At the beginning of each telehealth session, the therapist must verbally obtain from the patient the patient's name and document such name and the address of the patient's present location. Obtaining this information may lessen the possibility of impersonation of a client. Further, should an emergency situation arise, the therapist would be equipped with information regarding the client's location, which may change from session to session.
2. During each telehealth session, the therapist must assess whether the client is appropriate for telehealth, including but not limited to, consideration of the client's psychosocial situation.
3. For each session, the therapist must utilize industry best practices for telehealth to ensure both client confidentiality and the security of the communication medium.

### **Requirements for Emergency**

Therapist will plan to speak to each client individually prior to the first telehealth session and ask for the following information: 1st - the location description & addresses which may be used for your tele-health session. 2nd - emergency contact names and telephone numbers should they be needed in case of a mental health emergency which becomes evident during the telehealth session.

### **Mental Health Emergency Resources in San Diego**

1. *San Diego County Psychiatric Hospital located at 3853 Rosecrans Street, San Diego, CA 92110. Telephone: 619-692-8200.* Walk-in emergency mental health services are available for adults and older adults who are experiencing a mental health emergency or crisis at the Emergency Psychiatric Unit.
2. *Psychiatric Emergency Response Team (PERT):* PERT pairs licensed mental health clinicians with uniformed law enforcement officers/deputies and evaluates and assesses an individual's mental health condition and needs. If appropriate they transport the individual to a hospital or other treatment center or refer them to a community-based resource or treatment facility. PERT may be accessed through 9-1-1 and a request submitted for the PERT unit. This therapist will not hesitate to call PERT if a client indicates they are in immediate danger of harm.
3. *For Veterans: San Diego VAMC @ 3350 La Jolla Village Drive, San Diego, CA 92161.* Veterans Crisis Line 1-800-273-8255 & press "1" for Veterans. Also Urgent Mental Health Care Services: Psychiatric Emergency Clinic at 1-858-642-3654 or 1-800-331-8387, ext. 3654. Located on the 2nd floor from 8am-4pm or the Emergency Department at any other time.
4. *Walk-In Crisis Clinics:*
  - CENTRAL
    - Jane Westin Walk-In Center @ 1045 9th Ave., S.D., CA 92101**  
Phone: 619-235-2600 Hours 8am-10pm 7 days per week
    - UPAC Clinic @ 5348 University Ave., Suite 108, S.D., CA 92115**  
Phone: 619-255-7550 Hours 8:30 am - 5pm Mon-Fri

- EAST

**E. County M H Center @ 1000 Broadway, STE 210, El Cajon, CA 92021**

Phone: 619-401-5500 Hours 9am-12pm & 1pm -4pm Mon, Tues, Thurs & Fri; 1pm-4pm on Wed

**CRF H-land W R C @ 460 N. Magnolia Ave, STE 110, El Cajon, CA 92020**

Phone: 619-440-5133 Hours: Mon 9am-11am; Tues & Thurs 9am-4pm; Wed & Fri 9am-noon

- NORTH INLAND

**Exodus Recovery @ 1520 S Escondido Blvd., Esc. CA 92025**

Phone: 760-871-2020 Hours: 8am-4pm Mon - Fri

**MHS, Inc. N Inland MHC @ 125 W. Mission Ave., STE 103, Escondido, CA 92025**

Phone: 760 -747-3424 Hours: 8:30 am - 4:00 pm Mon-Fri

- NORTH CENTRAL

**N Central MHC @ 1250 Moreno Blvd, S.D., CA 92110**

Phone: 619-692-8750 Hours: 8:30 - 3:30 Mon-Fri

**CRF Douglas Young BPSR Center @ 10717 Camino Ruiz, STE 207, S.D., CA 92126**

Phone: 858-695-2211 Hours: 9-11am Mon, Tues, Wed, Fri. 12 Noon - 2 pm on Thurs

- SOUTH

**CRF South Bay Guidance @ 1196 3rd Ave., Chula Vista, CA 91911**

Phone: 619-427-4661 Hours: 9am-1pm Mon, Wed & Fri.

**CRF Maria Sardinias @ 1465 30th St., STE K, S.D., CA 92154**

Phone: 619-428-1000 Hours: 9am - 3pm Tues & Thurs

- NORTH COASTAL

**Exodus Recovery @ 524 W. Vista Way, Vista, CA 92083**

Phone: 760-758-1150 Hours: 9am-4:30pm Mon-Fri

**MHS, North Coastal @ 1701 Mission Ave., STE 210, OCN, CA 92058**

Phone: 760-712-3535 Hours: 9am-4pm Mon - Fri'

**Fee and Fee Arrangements**

This therapist will charge the usual and customary fee for a 50- minute telehealth session. This will be the same fee that has been decided upon by client and therapist at the initial face-to-face visit. The fee is based upon the client's income and the therapist's sliding scale.

**Third Party or Insurance Payments**

If a client's therapy is being paid for in full or in part by a 3rd party or Insurance Company, the therapist is responsible for ascertaining that the Insurance Company will cover telehealth sessions.

**Financial Agreement**

Charge per session: \$ \_\_\_\_\_

Amount paid by client: \$ \_\_\_\_\_

Amount paid by Third Party: \$ \_\_\_\_\_

Third Party Information (name, address, phone number): \_\_\_\_\_

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I give consent to New Day Women's Center to contact the Third Party named above to exchange information relevant to billing purposes only. ***I understand if the Third Party does not pay, for whatever reason, I am responsible for the entire charge per session.*** \*Note that NDWC scholarships and most insurance and 3<sup>rd</sup> party payers DO NOT cover short cancellation fees and "no show" fees. In these cases, the FULL session fee/rate must be paid by the client prior to scheduling the next session.

### **Appointments**

All appointments will be made through my therapist/counselor \_\_\_\_\_  
If an appointment cancellation or rescheduling becomes necessary, at least 24 hours advance notice is required to avoid being charged. As a courtesy, this enables other clients to utilize this time. ***Cancellations not made within 24-of the scheduled appointment are subject to a charge of 100% of the session fee.*** In the case of a no-show or cancellation, the client will be required to reschedule the next appointment; No appointment will be carried over without direct contact. Please be advised that I may refuse to reschedule an appointment for a client who has canceled or not shown repeatedly, or for a client who has a large outstanding balance and has not made a financial arrangement. Cash, checks, credit and debit cards are accepted as payment. ***Returned checks will be subject to a \$15.00 service fee.***

### **Confidentiality**

As a person in counseling you have certain rights of which you should be aware. They are as follows:

1. You have the right to decide not to receive psychotherapy from me, or to end therapy at any time without any moral or legal obligations.
2. You have the right to ask any questions about the procedures or techniques used during therapy and to prevent the use of certain therapeutic techniques if you are not comfortable with them.
3. One of your most important rights involves confidentiality. No information, including the fact that you are in therapy or any particular appointment time, will be released without your written consent, within certain limits. Those limits are imposed by law and are as follows:
  - If you threaten grave bodily harm or death to another person, I must inform the person and the appropriate law agency.
  - If a court of law issues a legitimate subpoena I must provide the information specifically requested.
  - If you are in therapy or being tested by order of court of law the results of the treatment or tests must be revealed to the court.
  - If there is evidence to suspect child abuse either by neglect, assault, battery, or sexual molestation, I must report it to the appropriate agency.
  - If you disclose viewing of child pornography, I must report to the appropriate agency (Code AB1775)

- If there is evidence to suspect elder and/or dependent adult abuse I must report the reasonable suspicion to the appropriate agency.
- In the case of potential suicide, I am allowed by law to inform the necessary individuals and/or agencies to prevent harm

I am mandated by law to reveal the above information obtained during therapy to other persons or agencies without your permission and I am not required by law to inform you of my actions in this regard.

### **Acknowledgement**

All please read this agreement for services carefully and make sure you understand its terms and conditions. Please discuss any terms or conditions with Therapist should you have any questions. Client agrees to abide by the terms and conditions of this Agreement and consents to participate in Telehealth psychotherapy with Therapist.

Clients may give verbal agreement to the therapist over the phone. However, it would be appreciated if you would send this message to the therapist email (pvokeylong@yahoo.com ) to be placed in your records. ***“I have read New Day Women’s Center’s Informed Consent for Telemedicine and agree to its terms and conditions” and then sign your name and give the date.*** If you are in a person-person session, you may sign below.

Patient name (please print): \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_