GRAVEN & ASSOCIATES

psychology • neuropsychology

# CONSENT FOR TELEHEALTH SERVICES

I _____ [name of patient] understand that the purpose of this consent form is to inform me of the risks and benefits of receiving care via telehealth and to provide information on the terms under which telehealth services will be made available to me. If I consent to receive telehealth services as described in this form, I acknowledge that I may receive telehealth services from a Graven & Associates, PLLC employed provider or from an independent health care provider under contract with but not employed by Graven & Associates, PLLC.

I understand that "telehealth" includes the practice of health care delivery, assessment, diagnosis, consultation, treatment, transfer of medical data, and psychoeducation using interactive audio, video, or data communications between a provider and a patient who are not in the same physical location. **Telehealth appointments are considered outpatient services and not intended as a substitute for emergency or crisis services.** Crisis or mental health emergencies should be addressed by presenting to your nearest hospital or by calling 911. If there is a disruption in technology then you may call the office at 502-690-8024 to talk to your provider, and your provider may also try to contact you at the number you have listed in your chart.

The laws and professional standards that apply to in-office services also apply to telehealth services. This document does not replace other agreements, contracts, or documentation of informed consent.

## TECHNOLOGY

I understand that I may need to download an application and/or software to receive telehealth services. I also need to have a broadband internet connection or a smart phone device with a good cellular connection at home or at the location deemed appropriate for services. Any electronic devices I use must be fully charged before the service will be rendered. I also understand that in case of technology failure, I may contact my Graven & Associates, PLLC provider or the office via phone to coordinate alternative methods of treatment (e.g., in office care).

I agree to use my own equipment (e.g., computer, video camera) to communicate and not equipment owned by another, and specifically agree not to use my employer's computer or network. I am aware that any information I enter into an employer's computer can be considered by the courts to belong to my employer and my privacy may thus be compromised.

As a general practice Graven & Associates, PLLC DOES NOT record telehealth sessions without prior permission. If telehealth sessions are recorded, the digital recording will be shared and stored in accordance with privacy requirements and HIPAA regulations. In addition, the telehealth platform(s) utilized for telehealth services will employ security safeguards to protect the privacy and security of health information and imaging data, and will include measures to safeguard the security and integrity of your health information during a session.

Telehealth services rely on technology, which allows for greater convenience in service delivery. You acknowledge and understand that your private health information may be transmitted from your provider's mobile or other computing device to your own or from your device to that of your provider via a technology vendor's application. There are risks in transmitting information using technology that include, but are not

limited to, breaches of confidentiality or privacy of personal health information, theft of personal information, disruption of service due to technical difficulties, and risks that the information or communication will be intercepted by an unauthorized person or persons. The use of telehealth is a new delivery method in an area not fully researched that has potential risks which may include some areas that are not yet recognized.

Among the risks of telehealth 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. If your provider is concerned about you and there is a lost connection they may call one of your emergency contacts to check on you or may call 911 for a well check.

**RIGHTS AND CONSENT TO TELEHEALTH**

1. I understand that I have the right to cease treatment at any time.
2. I understand that there are risks and consequences associated with telehealth including, but not limited to the risks listed above and the possibility, despite reasonable efforts on the part of my provider, that the transmission of my medical information could be disrupted or distorted by technical failures.
3. I understand that telehealth-based services and care may not be as complete as in office (or in person, face-to-face) services.
4. I understand that if my provider believes I would be better served by another form of therapeutic services (e.g. in- office or face-to-face services) they can discontinue telehealth therapy sessions with me and I can make an in-office appointment with my provider. However, if that is not possible then I will be referred to a provider who can provide such services in my geographic area. It is my responsibility to contact such providers in my area. I recognized that I can find providers by contacting my insurance, consulting with my primary care physician, and/or by connecting to my state's psychological association.
5. I understand that I may benefit from telehealth but that results cannot be guaranteed or assured.
6. I understand that I must be physically in the state my provider is licensed in to receive telehealth services. For example, if my provider is licensed in Kentucky then I must physically be present in Kentucky to participate in telehealth treatment.
7. I understand it is my responsibility to maintain privacy on the patient end of communication.
8. I understand that the physical setting I am in during a telehealth session will be private and free from disruptions and will not have other individuals present unless a valid written consent is on file for them to participate in my care.
9. I understand 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.
10. I understand and consent to participate in technology-based consultation and other healthcare-related information exchanges with my provider to receive services via telehealth. This means that I authorize information, data, and communications related to my medical information and mental health to be electronically transmitted, and to be stored incident to such transmission, through an interactive video connection to and from: my provider using a telehealth platform, any third-party technology vendor providing the telehealth platform or application, other persons involved in my health care, and the staff operating the equipment.
11. I understand that security protocols utilized in the provision of telehealth could fail, resulting in

unauthorized access to or interception of my personal health information.

12. I understand that if I am deemed a danger to myself or others then I will not seek a telehealth session and instead agree to seek care immediately through my own local health care provider or at the nearest hospital emergency department or by calling 911.
13. I understand that the exchange of information will not be in person and any paperwork exchanged will likely be provided through electronic means or through postal delivery.
14. I agree that if I utilize an electronic signature to sign this consent for telehealth services or any other forms related to the provision of telehealth that I intend my electronic signature to have the same binding legal effect as my physical written signature.
15. I understand that I must be present in the platform waiting room 5 minutes before my appointment to be seen on time.

**INSURANCE**

It is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. However, it is your responsibility to know what your insurance policy covers and you (not your insurance company) are responsible for full payment of your provider's fees**. THIS INCLUDES TELEHEALTH.** Further, your provider is not on every insurance panel so it is important that you verify the provider's participation in your network if you will be using your insurance benefits. Ultimately, you are responsible for maintaining coverage through your health insurance. You should also be aware that most insurance companies require you to authorize your provider to provide them with a clinical diagnosis. Sometimes your provider has to provide additional clinical information such as treatment plans, summaries of treatment, copies of an evaluation, or the entire record. By signing this Informed Consent for Treatment you are giving Graven & Associates, PLLC consent to provide treatment information to your insurance company.

**PROFESSIONAL FEE POLICY**

Charges for services are due and payable in full at the time the services are rendered. If you have health insurance coverage, a claim form will be filed on your behalf. In the event the insurance rejects your claim, the amount paid is based on Graven & Associates, PLLC regular fee schedule. You are responsible for paying the balance owed on your account immediately. Your account can be settled using cash, check or credit card. If a statement remains unpaid after sixty (60) days and no satisfactory arrangements have been made, we will pursue collection to the fullest extent permitted by law, which may include the account being sent to collections or small claims court. The cost of any such proceedings will be included in the claim.

**APPOINTMENTS**

All telehealth services must be scheduled ahead of time pending scheduling availability and provider discretion. Our providers normally conduct a 45- to 60-minute intake evaluation. It is up to the provider's discretion if this first appointment is conducted as a telehealth session. During this time, you can work with your provider to decide if they are the best person to provide the services you need in order to meet your treatment goals. You can discuss with them the frequency and type of therapy (i.e., individual, couples, family) that would be most beneficial to reduce your symptoms. Once an appointment time is scheduled, you will be expected to pay for it unless you provide 48 hours (2 day) advance notice of cancellation unless you and your provider agree that you were unable to attend due to circumstances beyond your control. Appointments scheduled for Monday must be cancelled by 4:00 PM on Friday. Work, school and/or social obligations are not considered circumstances beyond your control. Insurance does not pay for missed sessions. *In addition, appointment reminders are a courtesy and it is your responsibility to know the date and time of your appointment.*

## ACKNOWLEDGEMENTS

I understand that my provider will regularly reassess the appropriateness of continuing to deliver services to me through telehealth means and will modify my care plan as needed. This document has explained how telehealth health services are performed and I understand that telehealth sessions will differ from in-person services, including but not limited to emotional reactions that may be prevented or stunted by the use of technology. In addition, some information that could be obtained in an in-office appointment may not be available with a telehealth session. I understand that such missing information could make it more difficult for my provider to understand my symptoms or problems and help me get better. I also understand that my provider will be unable to physically touch me or to render any emergency assistance if I experience a crisis.

## EMERGENCY CONTACTS

These are the names and telephone numbers of my local emergency contacts (including local physician; crisis hotline; trusted family, friend, and/or adviser).

| Name | Relationship | Telephone Number |
|---|---|---|
| Name | Relationship | Telephone Number |
| Name | Relationship | Telephone Number |

## RELEASE OF LIABILITY:

I unconditionally release and discharge Graven & Associates, PLLC, its affiliates, agents, employees; billing services contractor, its affiliates, agents, and employees; and my provider and his or her designees from any liability in connection with my participation in the telehealth treatment.

I have read this document carefully and fully understand the benefits and risks. I understand the costs associated with my receipt of telehealth services and I agree to pay amounts due on my account. I have had the opportunity to ask any questions I have and have received satisfactory answers.

With this knowledge, I voluntarily consent to participate in telehealth treatment, including but not limited to any care, treatment, and services deemed necessary and advisable, under the terms described herein.

**Signing below indicates agreement to the above information and terms.**

_____ _____

Patient Name Date

_____ _____

Patient Signature (if age 16 or older) Parent/Legal Guardian Signature

Authorized Representative Relationship/Authority *(CIRCLE ONE):* Self Parent Guardian Other:_____