Agreement (Consent) to Use Telehealth Services

I,_____, agree (consent) to receive psychological treatment over the telephone and/or computer from Providence Health & Services (Providence). This method of providing care is called "telehealth".

Information about telehealth services

- Receiving treatment using telehealth will help you access services and work towards your treatment goals.
- Telehealth services may include evaluation, assessment, consultation, treatment planning, and psychological coaching and counseling.
- To help protect your privacy, telehealth is provided primarily through platforms that meet HIPAA standards. This includes audio, video, telephone or other communication platforms. HIPAA is a federal law that, in part, protects your privacy as a patient.
- In some circumstances during the COVID -19 outbreak, platforms may need to be used that do not fully meet HIPAA guidelines. If a platform is used that does not fully meet HIPAA standards, your provider will do their best to ensure your services meet as many HIPPA guidelines as possible.

I understand that I have the following rights with respect to using telehealth services:

1. I have the right to withhold or cancel my consent at any time without affecting my right to receive care or treatment in the future.
2. The HIPAA laws that protect the privacy of my personal information also apply to telehealth.
    a) I understand the information shared by me during my individual sessions is confidential.
    b) If information is shared within a group, all members agree to keep that information confidential.
    c) I understand that any images that can be identified as me or information about me that is obtained as a result of using telehealth services through Providence cannot be shared with other entities without my written consent.
    d) I understand that I am expected to participate in the therapeutic contact in real time and agree not to record the session.
3. I understand that there are risks and consequences from using telehealth. These include, but are not limited to:
    - The possibility, despite reasonable efforts on the part of Providence, that the transmission of my personal information could be disrupted or distorted by technical failures.
    - The transmission of my personal information could be interrupted by unauthorized persons.

- That psychological services using telehealth may not be as complete as in-person services.

4. I understand that if my provider believes I would be best served by another method of care, such as in-person treatment, that I will be referred to a provider who can provide these services in my area.
5. I agree that if I am in crisis or experiencing a medical or psychiatric emergency, I will immediately call 911 or go to the nearest hospital or crisis facility, and not use telehealth services in these situations.
6. By signing this document, I understand that an emergency situation may include:
    - Thoughts about hurting or harming myself or others.
    - Experiencing a life threatening situation.
    - Experiencing other concerns which may present a risk to my immediate safety.
7. If I am joining a group that includes video, I will do so in a private space to maintain confidentiality for other group members. If I am unable to meet in a private space, I will only use an audio option and will do my best to keep the audio of the session private.

By signing this agreement, I acknowledge that:

- I have read the above information.
- I have had the opportunity to ask questions about any of the information in the agreement.
- I understand the above information and agree to participate in telehealth services from Providence.

Client or Legal Guardian Signature: _____

Date: _____

Client's Printed Name: _____

Client's Email Address:_____

Client's Address (your physical location during telehealth sessions) and phone number:

_____

Emergency Contact Name and Telephone Number: _____

_____