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TELEMENTAL HEALTH THERAPY SERVICES AGREEMENT

Patient Name: _____ D.O.B._____

1. Telemental health services are an alternative form of therapy or adjunct therapy with several limitations. For example, there is a risk of misunderstanding one another due to lack of visual or auditory cues and there is a risk of disruption to the service (e.g., inability to connect, unauthorized access, and technical difficulties) that can disrupt the flow of the session I understand these potential risks to using this technology and that my health care provider or I can discontinue the telemental health session if it is felt that the videoconferencing connections are not adequate for the situation or for any other reason.

2. My health care provider has explained to me how the video conferencing technology will be used and it will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider. I have had the alternatives to a telemental health session explained to me.

3. I agree to inform my clinician of my address/location at the beginning of each telemental health session. I understand that notifying my clinician of my location is in my best interest in the case of an emergency. This may include if I am having suicidal or homicidal ideations and plans, and/or intent to act out my plans; if I am in crisis that cannot be resolved remotely; if I am experiencing psychotic symptoms; and if my clinician determines I need a higher level of care and telemental health services are not appropriate. I understand that in the event of an emergency, my clinician may need to contact emergency services to further assess for safety (e.g., may send police or an ambulance to the home for a welfare check) and/or provide transportation to the nearest local hospital if I am not able to transport myself voluntarily.

4. I understand that my clinician is licensed in the state of West Virginia and that I can only participate in telemental health services if I, myself, am also in West Virginia, unless otherwise stated by my clinician (who may have multiple licenses, or are involved in PSYPACT).

5. I understand that the program for video conferencing is HIPAA compliant and no images or information from these sessions will be disseminated without written consent. There are other limits to confidentiality to be mindful of as well, including that individuals near you may overhear your communications or have access to the platform that you are using. I understand that I am responsible for my surroundings and will make attempts to engage in telemental health sessions privately, in a quiet space, without distractions,

unless I provide permission for another person to be close/near me while I participate in sessions.

6. I agree to conduct myself in telemental health sessions as I would if in the office participating in a face-to-face session. This includes wearing appropriate clothing, refraining from substance use, not engaging in sessions while driving, and not using the restroom while in session.

7. I understand the billing will occur from my practitioner and that the structure and cost of telemental health sessions are equal to face-to-face sessions.

8. I agree that I will not record any telemental health sessions.

9. I understand that I have the right to review documentation regarding any transmitted medical information.

10. My clinician may recommend that I visit certain websites or phone applications for self-help (e.g., the Calm app, Breathing apps, or Headspace) to enhance your treatment. The applications and/or websites may have tracking devices that allow automated software to know I've visited these sites or applications and they may attempt to sell me other products using information I've provided. Anyone who has access to my device(s) may see that I have been to these sites or used these applications by viewing my history. By signing this agreement, I understand that it is my responsibility to decide if I would like to use these applications/websites as part of my treatment.

11. I have had a direct conversation with my therapist, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in language I understand.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of the process.
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

_____ _____
Patient's/parent/guardian signature Date

_____ _____
Witness signature Date

_____ Verbal consent given _____ _____
Date Time

_____/_____
Witness Print/Signature