GREATER SEACOAST COMMUNITY HEALTH

Goodwin Community Health | Families First | Lilac City Pediatrics

Notice to Clients and Consent to Tele-Behavioral Health Services Treatment Agreement

1. I understand that tele-Behavioral Health therapy involves the use of either an encrypted audio/video application that complies with HIPAA (Health Insurance Portability and Accountability Act) or a HIPAA-compliant telephone platform to communicate with my Behavioral Health therapist during my therapy sessions.

2. I understand that tele-Behavioral Health sessions will follow the same format, time-frames and structure as face-to-face sessions. I understand that information and notes from these sessions will be stored in the same way as face-to-face Behavioral Health sessions. I also understand that all patient policies and procedures of Greater Seacoast Community Health continue to apply.

3. I understand that the laws that protect the confidentiality of my medical information in face-to-face sessions also apply to tele-Behavioral Health sessions. I understand that the information disclosed by me through tele-behavioral health during the course of my therapy is generally confidential. However, the mandatory reporting exceptions to confidentiality that apply in face-to-face sessions also apply to tele-behavioral health sessions.

4. I understand that to ensure my safety I must provide my therapist with the address of where I am located during my tele-Behavioral Health sessions along with my phone number and the name and number of an emergency contact.

5. I understand that if during a tele-Behavioral Health session, my therapist suspects that I am at imminent risk of harm to myself or others, that by law, my therapist must contact the authorities to ensure safety for myself and others.

6. I understand that it is my responsibility to insure the confidentiality of tele-Behavioral Health sessions in the environment in which I participate. I further understand that my provider may also elect to reschedule the session.

7. I understand that no dissemination of any personally identifiable images or information from the tele-Behavioral Health session will occur without my written consent.

8. I understand that I have the right to withhold or withdraw consent at any time without impacting my right to future treatment or risking the loss or withdrawal of any Greater Seacoast Community Health services to which I would otherwise be entitled.

NAME: _____ DOB: _____

9. I understand that there are both risks and benefits associated with tele-Behavioral Health therapy.

a. Benefits may include increased access for those who may be challenged by geographic location, transportation, and/or other barriers. Though I understand that I may benefit from tele-Behavioral Health therapy, I also understand that results cannot be guaranteed or assured.

b. Risks related to tele-Behavioral Health therapy include certain limits to confidentiality in electronic communication. These risks include, but are not limited to, the possibility, despite reasonable efforts on the part of my behavioral health provider, that the video (or telephone) interaction between me and my behavioral health therapist could be interrupted due to technical failures or faulty internet connection; and the potential for confidentiality breaches due to technical failures. These risks will be offset with the use of our chosen platform. Furthermore, when using the video platform, the contents of my behavioral health counselor's computer are encrypted to further ensure my privacy and confidentiality.

ACKNOWLEDGEMENT AND ACCEPTANCE

My signature below indicates that I have read and understand this document and have discussed the contents with my Behavioral Health counselor. This signature also indicates my consent for tele-Behavioral Health services.

_____ _____

Patient Signature Date of Birth Date

_____ _____

Patient Email Patient Phone Number

_____ _____

Clinician Signature Date