DISCLOSURE AND INFORMED CONSENT

Telemental Health Counseling Sessions

Patient Information

Name: ______________________________ DOB: ________________ Age: ________

Gender: ❑ Male ❑ Female

Primary Language: ______________________ Do you require interpretive services? ❑ Yes ❑ No

Address: ____

City: ______________________ State: ______________ Zip Code: ____________

Phone: 1st contact #: ____________ 2nd contact #: ____________ Email: ______________________

Overview of Telemental Health Sessions

Telemental Health refers to psychotherapy services that occur via a virtual, electronic platform. Providers are required to use platforms that meet specific HIPAA compliance requirements and are designed to protect your personal health information. Innovative Health Care uses Theranest, an electronic platform designed for the provision of mental health services. Theranest meets all requirements for HIPAA compliance and therefore, is an acceptable platform for the provision of Telemental Health services.

Access to Care

In order to participate in a Telemental Health session, you and your provider must first determine if you are a candidate for this method of service delivery. Some reasons for the provision of Telemental Health services may be because you live in a rural area and do not have access to traditional methods of service delivery. You may have a condition that prevents you from leaving your home, or you may have limited transportation that prevents you from accessing face to face sessions. In order to access Telemental Health services, you must have the following:

- The ability to see and hear through an electronic device such as your laptop, desktop computer, tablet, or smart phone
- A private and safe space to participate in the session
- Enough knowledge of electronic systems to access the Telemental Health site and navigate appropriate options
- An email address

Conflict of Interest

Our clinicians do not receive a financial benefit for delivering Telemental Health services versus traditional face to face sessions. Reimbursement is the same regardless of the treatment location and modality.

Insurance/Payment Policy:

Your insurance will be billed for Telemental Health services the same as if you were meeting face to face. The only indication your service was delivered via virtual means will be a modifier used during billing of "GT."

I authorize the release of any medical information necessary to process any claim. I permit a copy of the authorization to be used in place of the original. This authorization may be revoked by either me or the Employer Benefits Manager at any time in writing.

Initial ________

Medical Consent

I consent to the services which may be performed as a patient, on an outpatient basis, within the scope of practice authorized under the licenses of the respective licensed providers. In agreeing to participate in virtual counseling sessions, I understand that there may be technical difficulties that will need to be resolved and that, even though IHCC uses a secure two-way real time interactive telemental health system, as with any electronic system, there is the risk of data breach and my personal health information may be at risk of exposure. I understand that I can terminate my sessions at any time.

Initial ________

Release of Information

I acknowledge that IHCC will use my information for the purpose of diagnostics, assessment, payment, and health care operations. I authorize IHCC, and any staff member involved in my care, to release medical information and supporting documentation of the same as compiled in my medical records during the time of services or reasonable follow-up period to any organization which is or may be liable

or responsible for payment of charges associated with my care and for all other purposes of benefit payment. I acknowledge that data from my patient records will be accessible to all health care, social service providers, and educational institutions participating in my care and treatment, including but not limited to physicians, psychiatrists, therapists, diagnosticians, nurses, technicians, and such other health care or mental health care agencies involved in my care with a valid release. This information may also be provided to educational institutions in which the patient is enrolled upon request. I further acknowledge that my medical records may be utilized in IHCC's utilization review. I also acknowledge that information contained in my medical records may be extracted and compiled for research purposes and the aggregated results (without individually identifying me) may be released to the public. I acknowledge that my medical records may also be made available to governmental agencies as required by law. I acknowledge that patient medical records may be stored electronically and made available through secure computer networks to IHCC staff personnel.

Certification of true, correct, and complete information

I certify that the information given or will be given by me or upon my behalf is true, correct, and complete. I certify that I have not nor will not withhold any information that is reasonably requested. I understand that withholding information can have a serious negative impact on the quality of services provided, including resulting in an inaccurate diagnosis. This includes but is not limited to prior medical, mental health, or behavioral history; family history of potentially related medical, mental health, or behavioral symptoms; use of pre-natal use of alcohol, drugs, or tobacco; pre-natal and birth abnormalities or incidents; child abuse or injury; injuries to the head; history of cancer or blood disease, etc.

I hereby certify and state that I have read, and that I fully and completely understand the conditions for services, and that I sign knowingly, freely, and voluntarily. Moreover, I certify and state that I have received no promises, assurances, or guarantees from anyone as to the results that may be obtained based upon the diagnoses or results from sessions. I further certify that the information I provide is true, correct, and complete, and certify the foregoing acknowledgements, understandings, and certifications.

____ ________________________

Client or Responsible Party Printed Name | Relationship to Client

____ ________________________

Patient or Responsible Party Signature | Date