



LIFEPATH THERAPY
— ASSOCIATES —

TELEBEHAVIORAL HEALTH INFORMED CONSENT

As a client or patient receiving behavioral services through telebehavioral health technologies, I understand:

Telebehavioral health is the delivery of behavioral health services using interactive technologies (use of audio, video or other electronic communications) between a practitioner and a client/patient who are not in the same physical location. The interactive technologies used in telebehavioral health incorporate network and software security protocols to protect the confidentiality of client/patient information transmitted via any electronic channel. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption. *Electronic systems used will incorporate network and software security protocols to protect the privacy and security of health information and imaging data, and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption.*

1. This service is provided by technology (including but not limited to video, phone, text, apps and email) and may not involve direct face to face communication. There are benefits and limitations to this service. I will need access to, and familiarity with, the appropriate technology in order to participate in the service provided. The exchange of information will not be direct and any paperwork exchanged will likely be provided through electronic means or through postal delivery. *During your telebehavioral health consultation, details of your medical history and personal health information may be discussed with you or other behavioral health care professionals through the use of interactive video, audio or other telecommunications technology.*
2. If a need for direct, in-person services arises, it is my responsibility to contact my behavioral practitioner's office for an in-person appointment or my primary care physician if my behavioral practitioner is unavailable. I understand that an opening may not be immediately available in either office.
3. I may decline any telebehavioral health services at any time without jeopardizing my access to future care, services, and benefits.
4. These services rely on technology, which allows for greater convenience in service delivery. There are risks in transmitting information over technology that include, but are not limited to, breaches of confidentiality, theft of personal information, and

disruption of service due to technical difficulties. My practitioner and I will regularly reassess the appropriateness of continuing to deliver services to me through the use of the technologies we have agreed upon today, and modify our plan as needed.

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5. In emergencies, in the event of disruption of service, or for routine or administrative reasons, it may be necessary to communicate by other means:

a. In emergency situations, call client at:

b. Should service be disrupted, call client at:

c. For other communication, contact client at:

6. My practitioner may utilize alternative means of communication in the following circumstances

Telehealth sessions, scheduling sessions, _____

7. My practitioner will respond to communications and routine messages within 24 hours or other agreed upon timeframe.

7. It is my responsibility to maintain privacy on the client end of communication. Insurance companies, those authorized by the client, and those permitted by law may also have access to records or communications.

7. I will take the following precautions to ensure that my communications are directed only to my Clinician or other designated individuals:

Sessions in only a private and not a public location and on a device that is owned by me. _____

10. My communication exchanged with my therapist will be stored in the following Manner:

Telehealth sessions will not be recorded.

11. 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.

Client Printed Name

Signature of Client or Legal Guardian

Date

Printed Name of Practitioner

Signature of Practitioner

Date

Addendum A

Client/Patient Name: _____

I, the undersigned, a citizen of Illinois, or _____, (my designee(s), on my behalf, agree to participate in technology-based consultation and other healthcare-related information exchanges with LifePath Therapy Associates, LLC, a behavioral health care provider. This means that I authorize information related to my medical and behavioral health to be electronically transmitted in the form of images and data through an interactive video connection to and from the above-named practitioner, other persons involved in my health care, and the staff operating the consultation equipment. It may also mean that my private health information may be transmitted from my practitioner's mobile device to my own or from my device to that of my practitioner via an 'application' (abbreviated as "app").

You understand that a variety of alternative methods of behavioral health care may be available to you, and that you may choose one or more of these at any time. Your behavioral health care provider has explained the alternative to your satisfaction.

I represent that I am using my own equipment to communicate and not equipment owned by another, and specifically not using 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.

I understand that I will be informed of the identities of all parties present during the consultation or who have access to my personal health information and of the purpose for such individuals to have such access.

My health care practitioner has explained how the telebehavioral health consultation(s) is performed and how it will be used for my treatment. My behavioral practitioner has also explained how the consultation(s) will differ from in-person services, including but not limited to emotional reactions that may be generated by the technology.

You understand that it is your duty to inform your practitioner of electronic interactions regarding your care that you may have with other health care providers.

In brief, I understand that my practitioner will not be physically in my presence. Instead, we will see and hear each other electronically, or that other information such as information I enter into an "app" will be transmitted electronically to and from my practitioner and I. Regardless of the sophistication of today's technology, some information my practitioner would ordinarily get in in-person consultation may not be available in teleconsultation.

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I understand that such missing information could in some situations make it more difficult for my practitioner to understand my problems and to help me get better. My practitioner will be unable to physically touch me or to render any emergency assistance if I experience a crisis.

I understand that telebehavioral health is a new delivery method for professional services, in an area not yet fully validated by research, and may have potential risks, possibly including some that are not yet recognized. Among the risks 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.

In rare instances, security protocols could fail, causing a breach of privacy of personal health information. I understand that a physical examination may be performed by individuals at my location at the request of the consulting practitioner.

I authorize the release of any information pertaining to me determined by my practitioner, my other health care practitioners or by my insurance carrier to be relevant to the consultation(s) or processing of insurance claims, including but not limited to my name, Social Security number, birth date, diagnosis, treatment plan and other clinical or medical record information.

I understand that at any time, the consultation(s) can be discontinued either by me or by my designee or by my health care practitioners. I further understand that I do not have to answer any question that I feel is inappropriate or whose answer I do not wish persons present to hear; that any refusal to participate in the consultation(s) or use of technology will not affect my continued treatment and that no action will be taken against me. I acknowledge, however, that diagnosis depends on information, and treatment depends on diagnosis, so if I withhold information, I assume the risk that a diagnosis might not be made or might be made incorrectly. Were that to happen, my telehealth-based treatment might be less successful than it otherwise would be, or it could fail entirely.

I also understand that, under the law, and regardless of what form of communication I use in working with my practitioner, my practitioner may be required to report to the authorities information suggesting that I have engaged in behaviors that endanger others.

The alternatives to the consultation(s) have been explained to me, including their risks and benefits, as well as the risks and benefits of doing without treatment. I understand that I can still pursue in-person consultations. I understand that the telebehavioral health consultation(s) does not necessarily eliminate my need to see a specialist in person, and I have received no guarantee as to the telebehavioral consultation's effectiveness.

I understand that my telebehavioral consultation(s) may be recorded and stored electronically as part of my medical records. I understand that consultations, test results, and disclosures will be held in confidence subject to state and/or federal law.

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I understand that I am ordinarily guaranteed access to my records and that copies of records of consultation(s) are available to me on my written request. I also understand, however, that if my practitioner, in the exercise of professional judgment, concludes that providing my records to me could threaten the safety of a human being, myself or another person, he or she may rightfully decline to provide them. If such a request is made and honored, I understand that I retain sole responsibility for the confidentiality of the records released to me and that I may have to pay a reasonable fee to get a copy. Additionally, I understand that my records may be used for telehealth program evaluation, education, and research and that I will not be personally identified if such a use occurs. I hereby authorize these disclosures to take place without prior written consent.

I understand that I am not entitled to royalties or to other forms of compensation for participation in any telebehavioral consultation(s) or other information exchange.

I have received a copy of my practitioner's contact information, including his or her name, telephone number, pager and/or voice mail number, business address, mailing address, and e-mail address (if applicable). I have also been provided with a list of local support services in case of an emergency. I am aware that my practitioner may contact the proper authorities and/or my designated, local contact person in case of an emergency.

I acknowledge, however, that if I am facing or if I think I may be facing an emergency situation that could result in harm to me or to another person; I am not to seek a telebehavioral consultation. Instead, I agree to seek care immediately assistance at the nearest hospital emergency department or by calling 911.

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

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

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| Name | Telephone Number |
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| Name | Telephone Number |
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I unconditionally release and discharge _____ (name of organization), its affiliates, agents, employees; _____ (name of consulting organization), its affiliates, agents, and employees; and my practitioner and his or her designees from any liability in connection with my participation in the remote consultation(s).

I have read this document carefully and fully understand the benefits and risks. 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 the telebehavioral consultation(s), including but not limited to any care, treatment, and services deemed necessary and advisable, under the terms described herein.

Name

Date

Witness

The above release is given on behalf of _____ because the patient is a minor or has been determined to be incompetent to give medical consent for the following reasons:

Parent or Legal Guardian

Date

Time

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