Basset
Psychological Services, LLC

Informed Consent for Telehealth Services

DEFINITION OF TELEHEALTH

Telehealth involves the use of electronic communications to enable Basset Psychological Services, LLC (BPS) to connect with individuals using interactive video and audio communications. Telehealth includes the practice of behavioral health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data.

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

1. This service is provided by technology (including but not limited to video, phone, 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 to participate in the service provided. BPS uses secure, encrypted video transmission software to deliver telehealth. Exchange of information will not be direct, and any paperwork exchanged will likely be exchanged through electronic means or through postal delivery.
2. I understand that I have the right to withhold or withdraw my consent for the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
3. If a need for direct, face to face services arises, it is my responsibility to contact my treatment provider or another treatment provider in the area. I understand that an opening may not be immediately available.
4. I understand that I may expect the anticipated benefits such as improved access to care and more efficient evaluation and management from the use of telehealth in my care, but that no results can be guaranteed or assured.
5. I understand that these services rely on technology, which allows for greater convenience in service delivery. There are risks in transmitting information over the internet that include, but are not limited to breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties. My behavioral health provider and I will reassess the appropriateness of continuing to deliver services to me through the use of technology.
6. I understand the alternatives to services through telehealth as they have been explained to me, and in choosing to participate in telehealth, I am agreeing to participate using video conferencing technology.
7. I understand that if my treatment provider believes I would be better served by another form of intervention, I will be referred to another provider. In emergencies, the event of disruption of service, or for routine or administrative reasons, it may be necessary to communicate by other means:
    a. Should services be disrupted (internet connection is lost, battery dies, etc.) your therapist will contact you by phone or email. If you do not hear from your therapist or for administrative issues, you can contact your therapist by email or call the office at 513-271-9700.
    b. In emergency situations, please call 911 or go to the nearest emergency room.

c. If you have an urgent matter and need to talk to someone immediately, you can call Children's Mobile Crisis Services at 513-584-5098 or Psychiatric Intake Response Center at Children's Hospital at 513-636-4124.

8. It is my responsibility to maintain privacy on the client end of communication. I will take precautions to ensure that my communications are directed only to my behavioral health provider. (e.g., complete sessions in a private space in your home, adjust the volume on the device). I understand that using a private, secure internet connection is recommended. I understand that it is my responsibility to ensure antivirus and anti-malware software is up to date on my device.
9. The laws regarding exceptions to confidentiality of my personal information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my sessions is generally confidential. However, there are exceptions to confidentiality, including, but not limited to, reporting child, elder, and dependent adult abuse; expressed threats of violence toward an ascertainable victim; imminent risk of suicide; and by Court Order. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent. No party will record the session without permission.
10. I understand that different states have different regulations for the use of telehealth. In Ohio, telehealth may only be conducted with clients located in the state of Ohio. As part of my participation, I agree to stay within the boundaries of Ohio for any services received.
11. If I wish to receive telehealth while in another state, I will notify my therapist at least two weeks prior. The therapist will only be able to meet via telehealth after talking to the appropriate regulating and licensing board in that state. I understand that the therapist may not receive permission to practice via telehealth in another state and therefore will not be able to render services while I am outside of Ohio.
12. The laws and professional standards that apply to in-person behavioral health services also apply to telehealth services. This document does not replace other agreements, contract, or documentation of informed consent.

PAYMENT FOR TELEHEALTH SERVICES

Fees for telehealth services are the same as in person sessions. You can pay by credit card at the time of session or mail a check to the office. You may authorize to keep your credit card information on file.

PATIENT CONSENT FOR THE USE OF TELEHEALTH

I have read and understand the information provided above regarding telehealth, have discussed it with my treatment provider, and all of my questions have been answered to my satisfaction. I have read this document carefully and understand the risks and benefits related to the use of telehealth services and have had my questions regarding the procedure explained. I hereby give my informed consent to participate in the use of telehealth services for treatment under the terms described herein. By signing, I hereby state that I have read, understood, and agree to the terms of this document.

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Client or Parent/Guardian Name

_____ _____

Signature Date