

INFORMED CONSENT FOR TELEHEALTH SERVICES

This Informed Consent for Telehealth Services document contains important information regarding Mary Beth Griffis and Wise Life Counsel Inc. services using the Internet or telephone. Please read this carefully and let me know if you have any questions. When you sign this document, it will represent an agreement between us.

Definition of Telehealth

Telehealth involves the use of electronic communications in real time to enable Wise Life Counsel Inc and Mary Beth Griffis, Licensed Mental Health Counselor, to connect with individuals and/or groups using interactive video and audio communications. Telehealth services do not include texting or email.

Telehealth includes the practice of psychological health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data.

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

- 1. The laws that protect the confidentiality of my personal information and records also apply to telehealth. As such, I understand that the information disclosed by me during the course of my sessions is confidential. Telehealth records are maintained just like in-office records. There are both mandatory and permissive exceptions to confidentiality, including, a court order, if I am a danger to myself or others, or there are indications of child abuse or elder abuse.*
- 2. I understand maintaining confidentiality is of utmost importance. This means you and your therapist both agree to not record telehealth sessions without the prior written consent of both parties.*
- 3. It is important that you protect the privacy of your session on your computer, cell phone or other device by making sure you are in a quiet, private place with a secure Internet connection and where the discussion cannot be overheard by other people. It also is important that you are in a space free of distractions where you will not be interrupted.*
- 4. I understand that although Wise Life Counsel Inc and Mary Beth Griffis utilizes password protected audio/video transmission software to deliver telehealth there are risks and consequences from telehealth, including, the possibility, despite reasonable efforts on the part of the counselor and the client, that: the transmission of my personal information could be disrupted or distorted by technical failures, the transmission of my personal information could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons outside of our control.*
- 5. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.*

Mary Beth Griffis MA LMHC
Wise Life Counsel Inc.
Fax: 407.671.6907

6. *I understand that my healthcare information may be shared with authorized individuals (your Insurance company for example) or for billing purposes. Confidentiality will only be broken with your consent or under the following circumstances:*
 1. *To report known or suspected child abuse or neglect to the Florida Department of Children and Families as required by law.*
 2. *To report known or suspected abuse of neglect of an elderly or disabled person to the Central Abuse Hotline as required by law.*
 3. *When there is serious threat to the health or safety of yourself or others. If a client intends to harm himself or herself, I will make every effort to enlist their cooperation in ensuring their safety. If they do not cooperate, I will take further measures without their permission that are provided to me by law to ensure their safety. If a client is threatening serious bodily harm to another person/s, I must notify the police and inform the intended victim.*
 4. *In certain judicial or administrative proceedings such as Health Oversight activities, unopposed subpoenas or court orders, certain law enforcement activities and Worker's Compensation claims.*

Please ask if you have any questions.
7. *By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio/video/computer-based psychotherapy services. If I am in crisis or in an emergency, I should immediately call 911, call Lifeline of Central Florida at 407-425-2624, or go to my nearest Emergency Room.*
8. *Wise Life Counsel Inc. and Mary Beth Griffis provide clinical services under licenses issued by and limited to practice within the state of Florida. Therefore, the client affirms they reside in the state of Florida at the time of telehealth services.*
9. *Note that treatment will be most effective when sessions occur at your regularly scheduled times and that Telehealth sessions will be treated in the same manner as in-person sessions: 24-hour/one-business day cancellation policy, etc.*
10. *Most research shows that Telehealth is about as effective as in-person therapy. However, some therapists believe that something can be lost by not being in the same room. We will decide together which kind of service is best for you.*
11. *You may require a certain computer or cell phone system in order to use Telehealth services. You are solely responsible for any cost to you to obtain any necessary equipment, accessories, or software to take part in Telehealth. At the time of the Telehealth appointment, it is your responsibility to have your electronic device on, video conferencing software launched, and be ready to start the session at the time of the scheduled Telehealth appointment.*
12. *The same fee rates apply for Telehealth sessions as apply for in-person therapy. Please pay Mary Beth Griffis before the end of your session.*

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13. *When conducting a Telehealth session, assessing and evaluating threats and other emergencies can be more difficult than in traditional in-person therapy. To address some of these difficulties, we ask that you complete the emergency plan included in this document before engaging in Telehealth services. In it, we ask you to identify an emergency contact person/support person who is near your location and whom your therapist will contact in the event of a crisis or emergency to assist in addressing the situation. Just like an in-person session, if your therapist doesn't hear from you, she will attempt to reach you but will discontinue after several attempts. If a video Telehealth session is blocked after several reasonable attempts, you may be open to having a telephone session for that time.*
14. *If you plan to file an out of network insurance claim, check with your insurance carrier beforehand to determine what types of Telehealth communications are covered and at what rates. Some insurance carriers do not cover Telehealth services or reimburse them at a lower rate*

By my signature below,

1. I hereby state that I have read the document carefully and understand and agree to the terms of this document.
2. I have read and understand the information provided above regarding Telehealth, have discussed it with my counselor, and all of my questions have been answered to my satisfaction.
3. 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.
4. I hereby request and consent to Telehealth services as a part of my treatment. I agree to abide by the terms of this agreement.

Client Name (Please print.)

Client Signature

Date

Therapist Signature

Date

Telehealth General Information and Emergency Plan

In case of a videoconferencing failure, I understand that my therapist will contact me by phone.

* Preferred Phone Number: _____ Alternate Phone Number: _____

* I agree to inform my therapist of the address of my physical location at the beginning of each session if different from the one listed below.

___ Yes, I agree. ___ No, I do not agree.

* Address of the location I intend to be for most of our Telehealth meetings at this time:

* Name, address, and phone number of closest Emergency Room:

Support Person

A support person is someone accessible to you (nearby, willing to help) during your Telehealth sessions. This individual could help in case of an emergency. You will need to sign a release of information to allow your therapist to contact this person if needed in such a situation.

* Support Person's Name: _____

* Support Person's Relationship to You: _____

* Support Person's Telephone Number(s): _____

* In case of emergency, I give consent for my therapist to contact my support person. I understand that this may involve disclosure of private and confidential information.

___ Yes, I consent. ___ No, I do not consent.

Standard Emergency Plan

If you have a mental health emergency, please follow the guidelines agreed to in this Informed Consent for Telehealth Services - dial 911, call Lifeline of Central Florida at 407-425-2624, or go to your nearest Emergency Room.

Client Name (Please print.)

Client Signature

Date