

BERNADETTE MULLINS MILLER, LLC

TELEBEHAVIORAL HEALTH INFORMED CONSENT

DEFINITION:

AS A CLIENT RECEIVING BEHAVIORAL HEALTH SERVICES THROUGH TECHNOLOGY, I UNDERSTAND:

TELEBEHAVIORALHEALTH IS THE DELIVERY OF BEHAVIORAL HEALTH SERVICES USING INTERACTIVE TECHNOLOGIES (AUDIO, VIDEO OR OTHER ELECTRONIC COMMUNICATIONS) BETWEEN AN PSYCHOTHERAPIST AND A CLIENT WHO ARE NOT IN THE SAME PHYSICAL ENVIRONMENT.

THE INTERACTIVE TECHNOLOGIES USED INCORPORATE NETWORK AND SOFTWARE SECURITY PROTOCOLS TO PROTECT THE CONFIDENTIALITY OF CLIENT INFORMATION TRANSMITTED VIA ANY ELECTRONIC CHANNEL. THESE PROTOCOLS INCLUDE MEASURES WHICH SAFEGUARD THE DATA AND AID IN PROTECTING AGAINST INTENTIONAL AND UNINTENTIONAL CORRUPTION.

SOFTWARE SECURITY PROTOCOLS:

ELECTRONIC SYSTEMS WILL INCORPORATE NETWORK AND SOFTWARE SECURITY PROTOCOLS TO PROTECT THE SAFETY OF HEALTH AND IMAGING DATA, AND WILL INCLUDE MEASURES TO SAFEGUARD THE DATA TO ENSURE ITS INTEGRITY AGAINST INTENTIONAL OR UNINTENTIONAL CORRUPTION. CURRENT SOFTWARE IS HIPPA COMPLIANT.

BENEFITS AND LIMITATIONS:

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 COMMUNICATIONS. THERE ARE BENEFITS AND LIMITATIONS TO THIS SERVICE.

REGARDLESS OF THE SOPHISTICATION OF TODAY'S TECHNOLOGY, SOME INFORMATION MY PRACTITIONER WOULD ORDINARILY GET IN AN IN-PERSON CONSULTATION MAY NOT BE AVAILABLE IN TELE-CONSULTATION. I UNDERSTAND THAT SUCH MISSING INFORMATION COULD IN SOME SITUATIONS MAKE IT MORE DIFFICULT FOR MY PRACTITIONER TO UNDERSTAND MY PROBLEMS AND ASSIST ME.

RISKS:

I UNDERSTAND THAT TELEBEHAVIORALHEALTH 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.

TECHNOLOGY REQUIREMENTS:

I WILL NEED ACCESS TO, AND FAMILIARITY WITH, THE APPROPRIATE TECHNOLOGY TO PARTICIPATE.

EXCHANGE OF INFORMATION:

THE EXCHANGE OF INFORMATION WILL NOT BE DIRECT AND ANY PAPERWORK EXCHANGED WILL LIKELY BE THROUGH ELECTRONIC MEANS OR THROUGH ELECTRONIC MEANS OR THROUGH POSTAL DELIVERY.

DURING MY TELEBEHAVIORALHEALTH CONSULTATION DETAILS OF MY MEDICAL HISTORY AND PERSONAL HEALTH INFORMATION MAY BE DISCUSSED WITH MYSELF AND OTHER BEHAVIORAL HEALTH CARE PROFESSIONALS THROUGH THE USE OF INTERACTIVE VIDEO, AUDIO OR OTHER TELECOMMUNICATIONS TECHNOLOGY.

SELF-TERMINATION:

I MAY DECLINE ANY TELEBEHAVIORALHEALTH SERVICES AT ANY TIME WITHOUT JEOPARDIZING MY ACCESS TO FUTURE CARE, SERVICES AND BENEFITS.

RISKS OF TECHNOLOGY:

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 ISSUES.

CLIENT COMMUNICATION:

IT IS MY RESPONSIBILITY TO SECURE A COMPLETELY PRIVATE SETTING, PREFERABLY A ROOM WITH A DOOR, AND SOUND INSULATION, WHILE COMMUNICATING WITH MY PSYCHOTHERAPIST. I FURTHER UNDERSTAND THAT NO OTHER INDIVIDUALS MAY BE PRESENT FOR THE TELEBEHAVIORALHEALTH SESSION UNLESS MUTUALLY AGREED UPON WITH MY THERAPIST.

PAYMENT FOR TELEBEHAVIORALHEALTH SERVICES:

THE PROCEDURE FOR PAYMENT IS THE SAME AS IN-OFFICE VISITS IN THAT PRIVATE PAY FEES, CO-PAYS, CO-INSURANCE AND SERVICES APPLIED TO ONE'S DEDUCTIBLE, ARE DUE AT THE TIME OF SERVICE. IT IS REQUESTED THAT EACH CLIENT COMPLETE A "CREDIT CARD AUTHORIZATION FORM" ALLOWING FOR TRANSACTIONS AT THE END OF YOUR SESSION. IN SELECT INSTANCES, AN INVOICE WILL BE EMAILED TO CLIENTS FOR SECURE ONLINE PAYMENT.

LAWS AND STANDARDS:

THE LAWS AND PROFESSIONAL STANDARDS THAT APPLY TO IN-PERSON BEHAVIORAL HEALTH SERVICES ALSO APPLY TO TELEBEHAVIORALHEALTH SERVICES. THIS DOCUMENT DOES NOT REPLACE OTHER AGREEMENTS, CONTRACTS OR DOCUMENTATION OF INFORMED CONSENT.

SIGNATURE

DATE

CREDIT CARD AUTHORIZATION FORM

PLEASE COMPLETE ALL FIELDS. YOU MAY CANCEL THIS AUTHORIZATION AT ANY TIME BY CONTACTING US. THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL CANCELLED.

CREDIT CARD INFORMATION:

CARD TYPE: (PLEASE CIRCLE)

MASTERCARD

VISA

DISCOVER

AMEX

OTHER _____

CARDHOLDER NAME (AS SHOWN ON CARD): _____

CARD NUMBER: _____

EXPIRATION DATE (MM/YY): _____ 3 DIGIT CVV FROM BACK OF CARD _____

CARDHOLDER BILLING ZIP CODE: _____

I, _____ AUTHORIZE BERNADETTE MULLINS MILLER, LLC TO CHARGE MY CREDIT CARD FOR AGREED UPON SERVICES. I UNDERSTAND THAT MY INFORMATION WILL BE SAVED TO FILE FOR FUTURE TRANSACTIONS ON MY ACCOUNT.

SIGNATURE

DATE