Roopa Baruah, LCSW, CCHt.

INFORMED CONSENT AND AGREEMENT FOR TELEMENTAL HEALTH

Telemental Health Services may be on the telephone or a secure online video platform.

I hereby consent to participate in telemental health with Roopa Baruah, LCSW, CCHt. as part of my psychotherapy. I understand that telemental health is the practice of delivering clinical health care services via technology-assisted media or other electronic means between a practitioner and a client who are located in two different locations.

Telehealth is healthcare provided by any means other than a face-to-face visit. In telehealth services, medical and mental health information is used for diagnosis, consultation, treatment, therapy, follow-up, and education. Health information is exchanged interactively from one site to another through electronic communications. Telephone consultation, videoconferencing, transmission of still images, e-health technologies, patient portals, and remote patient monitoring are all considered telehealth services.

I understand the following with respect to telemental health:

1. I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.
2. I understand that telehealth services can only be provided to patients, including myself, who are residing in the state of Texas at the time of this service.
3. I understand that telehealth billing information is collected in the same manner as a regular office visit. Payment is due at the time the service is rendered. I will provide a monthly receipt which you may choose to submit for out of network benefits with your insurance company.
4. I understand that there are risks, benefits, and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.
5. I understand that all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include but are not limited to:

   a. It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures.

   b. Electronic systems that are accessed by employers, friends, or others are not secure and should be avoided. It is important for me to use a secure network.

c. Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures.

6. There are potential risks, consequences, and benefits of teletherapy. **Potential benefits** include, but are not limited to improved communication capabilities, providing convenient access to up-to-date information, consultations, support, improved quality, change in the conditions of practice, improved access to therapy, better continuity of care, and reduction of lost work time and travel costs. Effective therapy is often facilitated when the therapist gathers within a session or a series of sessions, a multitude of observations, information, and experiences about the client. Therapists may make clinical assessments, diagnosis, and interventions based not only on direct verbal or auditory communications, written reports, and third-person consultations, but also from direct visual and olfactory observations, information, and experiences. When using information technology in therapy services, **potential risks include**, but are not limited to the therapist's inability to make visual and olfactory observations of clinically or therapeutically potentially relevant issues such as: your physical condition including deformities, apparent height and weight, body type, attractiveness relative to social and cultural norms or standards, gait and motor coordination, posture, work speed, any noteworthy mannerism or gestures, physical or medical conditions including bruises or injuries, basic grooming and hygiene including appropriateness of dress, eye contact (including any changes in the previously listed issues), sex, chronological and apparent age, ethnicity, facial and body language, and congruence of language and facial or bodily expression. Potential consequences thus include the therapist not being aware of what he or she would consider important information, that you may not recognize as significant to present verbally the therapist.
7. I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.
8. I agree that information exchanged during my telehealth visit will be maintained by the healthcare providers involved in my care.
9. I understand that medical information, including medical records, are governed by federal and state laws that apply to telehealth. This includes my right to access my own medical records (and copies of medical records).
10. I understand that I must take reasonable steps to protect myself from unauthorized use of my electronic communications by others.
11. The healthcare provider is not responsible for breaches of confidentiality caused by an independent third party or by me.
12. I agree that I have verified to my healthcare provider my identity and current location in connection with the telehealth services. I acknowledge that failure to comply with these procedures may terminate the telehealth visit.
13. I understand that I have a responsibility to verify the identity and credentials of the healthcare provider rendering my care via telehealth and to confirm that he or she is my healthcare provider.

14. I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telemental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).
15. I understand that electronic communication cannot be used for emergencies or time-sensitive matters.
16. I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.
17. I understand and agree that a mental health evaluation via telehealth may limit my healthcare provider's ability to fully diagnose a condition or disorder. As the patient, I agree to accept responsibility for following my healthcare provider's recommendations—including further diagnostic testing, such as a psychiatric evaluation with a physician or Crisis Stabilization Unit, or an in-office visit.
18. I understand that electronic communication may be used to communicate highly sensitive medical information, such as treatment for or information related to HIV/AIDS, sexually transmitted diseases, or addiction treatment (alcohol, drug dependence, etc.).
19. I understand that my healthcare provider may choose to forward my information to an authorized third party (such as Quartet or an EAP insurance company). Therefore, I have informed the healthcare provider of any information I do not wish to be transmitted through electronic communications.
20. I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, Roopa will call you to discuss since we may have to re-schedule.
21. By signing below, I understand the inherent risks of errors or deficiencies in the electronic transmission of health information and images during a telehealth visit.
22. I understand that there is never a warranty or guarantee as to a particular result or outcome related to a condition or diagnosis when medical care is provided.
23. To the extent permitted by law, I agree to waive and release my healthcare provider and his or her institution or practice from any claims I may have about the telehealth visit.
24. I understand that electronic communication should never be used for emergency communications or urgent requests. Emergency communications should be made to existing emergency 911 services in my community.
25. I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

Emergency Protocols

Your therapist needs to know your location in case of an emergency. You agree to inform Roopa Baruah, LCSW, CCHt. of the address where you are at the beginning of each session.

Roopa Baruah, LCSW, CCHt. also needs a contact person whom she may contact on your behalf in a life-threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

I will provide Roopa Baruah, LCSW, CCHt. with my emergency contact person's name, address, and phone number. I have the information provided above and discussed it with my therapist, Ms. Baruah. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

National Emergency

I understand that due to the state of the current national emergency crisis, telehealth is offered to appropriate patients in an effort to comply with federal and state mandates of isolation and social distancing as an effort to provide protection to everyone. The purpose of this visit is for the care of a mental health condition during the national emergency.

By e-signing this form or signing a physical copy, I certify that I have read and understand this agreement and that I've had the opportunity to have questions answered to my satisfaction.

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Client's Signature Date

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Printed Name