



Patient Agreement and Informed Consent To the Use of Telemedicine

PATIENT NAME: _____

DATE OF BIRTH: _____

This is an agreement between LaTonya McCurry Counseling Services, LLC and _____ regarding the use of tele-mental health services. The purpose of this form is to obtain consent to participate in tele-mental Health counseling services.

Tele-mental health services involve the use of electronic communications to enable healthcare providers at one location to provide counseling to patient in another location for continuing patient care. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

- Improved access to counseling services by enabling a patient to remain in his/her site (i.e. home) while the therapist provides services at distant/other sites.
- Prevents interruption in therapeutic care.

Possible Risks:

As with any medical procedure, there are potential risks associated with the use of tele-mental health. These risks include, but may not be limited to:

- In rare cases, the clinician may determine that the transmitted information or connection is of inadequate quality, thus necessitating a face-to-face meeting with the patient, or at least a rescheduled telehealth session;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- Clinician may determine that patient requires a higher level of care such as emergency care, hospitalization or crisis intervention and make necessary contact with patient's local crisis center, emergency room or police department.



As of _____, **LaTonya McCurry Counseling Services, LLC** and _____ will utilize **Doxy.me** to facilitate tele-mental health individual counseling sessions. These services will be provided until _____, when patient is able to secure attend treatment in office at the earliest date reasonable (within 3 months of date indicated above).

LaTonya McCurry Counseling Services, LLC agrees to each of the following that is checked:

- ✓ I am, and will remain, in compliance with all applicable laws, rules, regulations and state board requirements applicable to the delivery of Tele-mental Health counseling services, prescribing, coding requirements, and documented protocols (e.g., informed consent, emergency contact information)
- ✓ I will provide Tele-mental Health counseling services in a private and secure environment.
- ✓ The room to be used for Tele-mental Health counseling services will have adequate lighting and will be reasonably soundproof for patient privacy (such as white noise, etc).
- ✓ I will ensure that all documents containing protected health information or personal health information, including prescriptions, are transmitted securely in accordance with all privacy rules including HIPAA via the client portal.
- ✓ I have the appropriate protocols in place and have trained my staff on protocols and procedures related to technical or other types of failure that may disrupt service delivery.
- ✓ I understand and agree that I must hold and will only provide services when properly licensed according to state requirements for providing services within the state where the member is physically located at the time of the services.

By signing this "Informed Consent", _____ acknowledges that he/she understands and agrees with the following that is checked:

- I have completed and have provided informed consent, emergency contact information and will comply with clinical recommendations to follow up with the nearest crisis response center/ emergency room.
- I have the right to refuse or stop treatment without it affecting right to future care or treatment.
- I understand that I can choose the alternative of completing care with my current clinician, to seek care by a new clinician who may be located closer to my location.
- I will accept Tele-mental Health in a private and secure environment.
- The room to be used for Tele-mental Health will have adequate lighting and will be reasonably soundproof for patient privacy (such as white noise, etc).
- I understand that all documents containing protected health information or personal health information, including prescriptions, are transmitted securely in accordance with all privacy rules including HIPAA.
- I will follow Doxy.me's appropriate protocols and procedures related to technical or other types of failure that may disrupt service delivery (such as using the "test" button prior to each session to problem solve any technical difficulties).
- In case of disruption of tele-mental health session, I will quickly respond to clinician's phone call.
- I will hold LaTonya McCurry Counseling Services, LLC blameless for any disruption of services tele-mental health.

I have read and understand the information provided above regarding tele-mental health services carefully and understand the risks and benefits, have discussed it with my clinician and all of my questions have been answered to my satisfaction. I hereby give my informed consent to participate in tele-mental health services as described herein.

Patient Signature

08/01/18