WrightWay Ministries, LLC

1500 Pointer Ridge Place, #1585
Bowie, MD 20717
301.850.2391/3301.249.8030 (fax)
info@wright-waycounseling.com

Patient Information and Informed Consent for Telemental Health Services

By engaging WrightWay Ministries, LLC providers in any communication, inquiry, counseling or consulting, paid or unpaid, I am giving my consent and hereby understand that:

I am engaging in **Telemental Health** (professional services over the internet) with this provider for psychological, counseling or consultative services.

Telemental health includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. Telemental Health may involve the communication of my medical/mental information, both orally and visually, to other healthcare practitioners for continuity of care and/or peer review.

Potential benefits

- A computer and a webcam can provide live video conferencing using software that can be free to patients.
- Telemental health provides convenience and increased accessibility to mental health care for patients who are unable to be treated face to face due to various reasons such as living in remote locations, temporary circumstances such as being **away** at college, an extended stay away from home, having a physical limitation preventing travel to an office or natural disasters.
- I may benefit from Telemental Health, but just like in-person services, the results cannot be guaranteed or assured.

Potential Risks

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

- Despite reasonable efforts on the part of my provider, the transmission of my medical information could be disrupted or distorted by technical failure; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by authorized persons.
- Telemental Health-based services may not be the same as in-person services and that sometimes there may be a small delay or distortion of the video due to internet connectivity and bandwidth availability.
- Since my provider may not be immediately available, it is not advisable to initiate telemental health services for crisis situations unless an arrangement has previously been made for this purpose.
- The provider may not be able to provide for, or arrange for emergency care that I may require, in cases of connection failure.
- Due to the distant nature of these services, emergency assistance by the provider may not be available in a crisis. Local emergency services may called to assist me in a crisis if warranted and available. If I am unable to reach my provider in an emergency, I should call 911 or go to an emergency room.
- Although unlikely, security protocols can fail, causing a breach of privacy of my confidential medical information.

My Rights

- I understand that the laws that protect the privacy and confidentiality of medical information also apply to telemental health.
- I understand that the videoconferencing technology used by the provider is encrypted to prevent unauthorized access to my private medical information.
- I have the right to withdraw my consent at anytime and cease Telemental Health Services.
- I understand that the provider has the right to withhold or withdraw his or her consent for the use of telemental health during my care at any time.
- I understand that all the rules and regulations that apply to the practice of medicine in the state of Maryland also apply to telemental health, since the provider is located in Maryland.
- I understand that the provider will not record any of our telemental health sessions without my written consent.
- I understand that the provider will not allow any other individual to listen to, view or record my telemental health session without my written permission.

My Responsibilities

- I will not record any telemental health sessions without written consent from the provider. I am responsible for ensuring that I have a confidential place to speak with the provider for my telemental health visit. I am to notify the provider if anyone else is present or can overhear the telemental health visit. I understand that I, not the provider, am responsible for providing and configuring any electronic equipment used on my computer that is used for telemental health.
- I understand that it is my responsibility to ensure the proper functioning of all electronic equipment before my session begins.
- It is my responsibility to ensure that I have strong enough internet connection to perform a video call and that if I do not, I may still be charged for that session.
- If at anytime during my session the video or audio link is disconnected during our visit, I am to try the same link or number. I understand that I am to provide a phone number to the provider, of a phone I can answer if there is a disconnection and I am not able to re-establish the video call. Note: If this occurs as a result of the provider's connection, and you are not able to reconnect, you will not be charged for the session.
- I am responsible for ensuring the login information (username and password) to prevent a breach of my privacy.
- Since State licensing regulations for telemental health are different in each state, I, the client, will inform this provider, of the location in which I am located at the time of service and will inform the provider at least 24 hours prior to the session if this location changes.
- I have read and understand that all clinic policies of WrightWay Ministries apply to all telemental health sessions as well as all in-person visits, including the Consent and Service Agreement and Notice of Privacy Practices.
- I understand that I must provide emergency contact information for persons in my location and give consent for them to be contacted in case of medical or mental health emergencies prior to commencing telemental health treatment. I will provide the contact information of an emergency contact person who is available and willing to go to my location in the event of an emergency, and/or if the provider deems it necessary.
- I have the right to withdraw my consent at anytime and cease Telemental Health services.

I have read and understand the information provided above and all of my questions have been answered.

_____

Client Printed Name

_____ _____

Signature of Client or Legal Guardian Date

_____ _____

Signature of Practitioner Date

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Patient Consent for the Use of Telemental Health

I have read and understand the information provided in the "Patient Information and Informed Consent for Telemental Health Services" regarding Telemental health. I have discussed this information with my provider and all my questions have been answered to my satisfaction. I acknowledge that my participation in the Telemental health process is voluntary and may possibly increase the risk of disclosure of my medical data. I hereby give my informed consent for the use of Telemental health in my mental health care in the course of my diagnosis and treatment.

Patient Name: First_____ MI: _____ Last:

_____ Date of Birth: _____

Address: _____ City: _____ State: ____ Zip:

_____

County: _____

Email address: _____

Patient telephone contact: _____

Alternate contact: _____

Signature: _____ Date: ___/___/_____

Patient ( ) or Guardian ( )

Patient Signature or (authorized person if patient is under 18 years old): Relationship: _____

May be digitally signed by typing full name and date above and typing "I consent to these terms" on the line below:

Begin typing here: X_____

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Emergency Contact Information

Provide the contact information for two persons that your provider could contact in the case of a medical or mental emergency.

1) First_____ MI: _____ Last: _____

Date of Birth: _____

Address: _____ City: _____ State: ____ Zip:

_____ County: _____

Email address: _____

Patient telephone contact: _____

Alternate contact: _____

2) First_____ MI: _____ Last: _____

Date of Birth: _____

Address: _____ City: _____ State: ____ Zip:

_____ County: _____

Email address: _____

Patient telephone contact: _____

Alternate contact: _____