Patient Information and Informed Consent

for Telemental Health Service

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Telemental Health is the delivery of psychotherapeutic services using interactive audio and visual electronic systems and/or by the electronic transmission of information where the provider and the patient are not in the same physical location.

The interactive electronic systems incorporate network and software security protocols to protect patient information and safeguard the data exchanged.

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, or having a physical limitation preventing travel to our office.

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:

- Information transmitted electronically may not be sufficient (e.g., poor resolution of video) to allow for appropriate decision making by the psychiatrist or therapist.
- The provider is not able to provide every type of mental health treatment using interactive electronic equipment.
- The provider may not be able to provide for or arrange for emergency care that I may require, in cases of connection failure.
- Delays in mental health evaluation and treatment may occur due to deficiencies or failures of the equipment.
- Although unlikely, security protocols can fail, causing a breach of privacy of my confidential medical information.
- A lack of access to all the information that might be available in a face-to-face visit but not in a telemental health session may result in errors in clinical judgment.

Alternatives to the use of telemental health

- Face-to-face session in the mental health provider's office.
- Referral to another mental health provider.

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 withhold or withdraw my consent to the use of telemental health during the course of my care at any time. I understand that my withdrawal of consent will not affect any future care or treatment.
- I understand that the provider has the right to withhold or withdraw his or her consent for the use of telemental health during the course of my care at any time.
- I understand that the all rules and regulations that apply to the practice of medicine in the state of North Carolina and Georgia also apply to telemental health.
- 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 will inform the provider if any other person can hear or see any part of our session before the session begins. The provider will not allow any other person to hear or see any part of our session.
- 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.
- I have read and understand that all clinic policies of Alyce E. Wellons, LCSW apply to all telemedicine as well as all in-person visits, including the Therapist-Client Agreement and Notice of Privacy Practices.
- I understand that I agree to be seen face to face at least once a year to maintain therapeutic services, if deemed clinically necessary by the provider.
- I understand that the provider may require a face-to-face therapeutic relationship with my proposed telemental health provider prior to commencing telemental health treatment.
- 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 understand it is my responsibility to not be under the influence of alcohol, marijuana, or any substance that alters my ability to participate in a clear, present, and fully engaged in my therapeutic process.
- I understand this is a professional relationship and appointment, therefore, I will create a private, comfortable and secure space for my session. I will present myself in a manner consistent with an in-office visit.
- I understand it is my responsibility not to drive a car during my session in order to be fully engaged in my appointment.

Emergency Contact Information

There may be times in our work together that I feel you need immediate care from a hospital or physician. In these situations, I have the ability to have you evaluated.

☐By checking, you grant Alyce E. Wellons, LCSW, permission to seek emergency medical care from a hospital or physician if deemed necessary.

Provide the contact information for a person that your provider could contact in the case of medical or mental health emergencies.

Name: First: _____ MI: ____ Last: _____

Date of Birth: _____
Address: _____, City: _____,
State: _____ ZIP:_____ Country:_____
Email address: _____
Patient telephone contact: _____
Alternate method to contact:_____

Preferred hospital:_____

By signing, I understand that I have a read and understand the risks, rights and responsibilities of consenting to telemental health services. I also consent to have Alyce E. Wellons, LCSW seek emergency care if deemed necessary by her. If at any time I wish to discontinue these services, I will discuss my options with Alyce E. Wellons, LCSW.

Name: _____

Signature: _____

Date: _____

** Please scan or send a photo of your driver's license to alycewellons@hushmail.com **