Informed Consent for Telepsychology

The Platteville Family Resource Center, Inc. (PFRC), its staff, and its patients have endured and grown more resilient as a result of many natural and human made adversities over the last 25 years. PFRC has always, and will always, place foremost the health and welfare of its patients, staff, and the communities where we are located. The purpose of this form is to obtain your consent to participate in telepsychology services in lieu of face-to-face therapy session(s) in one of our clinical offices.

Telepsychology is the delivery of mental health services when the mental health provider and patient are not in the same physical location and communicate through the use of technology. Providers may include counselors, social workers, or psychologists. You are eligible to participate in PFRC telepsychology if:

- You are willing to be seen via telepsychology.
- You have access to a conventional telephone (without webcam), and/or a smart phone, tablet, or computer/laptop with webcam.
- You have access to WiFi, a cellular hotspot, or internet service.
- You have a private place where you can have sessions.
- If the PFRC patient is a child over 8-years-old and there is an adult caregiver that will be available in the home for safety and coordination purposes during telepsychology sessions.

Expected Benefits:

- Reduce risk of spreading or contracting any illness via face-to-face contact.
- Reduce waiting time for counseling.
- Avoid the need to travel.
- Flexibility in accessing and scheduling counseling.
- Easier access to quality counseling.
- Increased access for those with psychological conditions who many have difficulty attending an in-person session.
- More time for the patient to collect himself/herself/themself and to think about their thoughts, feelings, and behaviors when not in an in-person situation.
- The patient may be more comfortable doing telepsychology in their typical living environment.

Potential Risks with Telepsychology Technology:

- Interruption/disconnection of the audio/video link.
- Not recommended for patients suffering with severe mental illness (i.e. schizophrenia) or for those at risk of suicide.

- Capacity for crisis intervention may be limited.
- Patient may develop a type of virtual identity.
- Some of the problems that may occur in face-to-face therapy may not be as easily dealt with virtually.
- Misunderstandings may occur due to a lack of non-verbal cues or technology-based lags in communication.
- Confidential patient information could be compromised and made public due to lack of privacy in the patient's setting and through electronic interception.

The Platteville Family Resource Center, Inc. telepsychology responsibilities include:

- Provide telepsychology services to eligible PFRC patients.
- Provide and encourage PFRC patients to use only HIPPA compliant telepsychology services (Zoom).
- Provide ongoing scheduling and billing services.
- Protect patient health information provided by PFRC by the patient or patient's guardian.
- Follow best telepsychology practices.
- Comply with state and federal laws, regulations, and guidelines regarding telepsychology.
- Provide telepsychology services within normal PFRC business hours (M-Th 9am-7pm; Friday 9am-5pm) and within your therapist's clinical availability schedule.

Patient responsibilities include:

- Receive telepsychology services in a private, distraction free setting.
- Make sure to disconnect from the site at the end of the telepsychology session.
- Not use telepsychology when under the influence of street drugs, alcohol, or using prescription drugs in an unauthorized manner.
- If in crisis (i.e. suicidal) the patient or guardian will be directed to access crisis services and follow instructions.
- Do not use telepsychology outside of normal PFRC business hours (M-Th 9am-7pm; Friday 9am-5pm) and within your therapist's clinical availability schedule.
- Responsibility for any telepsychology fees incurred not reimbursed by your health insurance carrier (if applicable).
- Checking to ensure that telepsychology services are reimbursed by his/her/their health insurance.
- Patient will present themselves as if in provider's office.

Financial Considerations and Billing:

- Telepsychology services (i.e. video counseling, telephone counseling, email, etc.) may be covered by the patient's health insurance. It is the patient's responsibility to check to ensure that telepsychology services are reimbursed by his/her/their health insurance.

PFRC is not responsible for any charges incurred for any telephone/internet/satellite service interruptions or failures encountered, overage charges on data plans, technology failures, and any other costs associated with the telepsychology services that will be provided.

By signing this form, I understand the following:

- The laws that protect privacy and the confidentiality of the protected health information also apply to telepsychology and that no information obtained in the use of telepsychology which identifies me will be disclosed to researchers or other entities without my consent.
- I have the right to withdraw my consent to the use of telepsychology during my care and at any time without affecting my right to future care of treatment.
- There are potential risks to this technology, including interruptions, unauthorized access and technical difficulties and perhaps others not mentioned herein.
- That I may expect the anticipated benefits from the use of telepsychology in my care, but that no results can be guaranteed or assured.
- It is my responsibility to ensure my sessions take place in a private location ideally a room with a door or a part of the home away from other interruptions.

TELEPSYCHOLOGY LOCATION OF PATIENT: _____

DATE OF BIRTH: _____

Mental Health Provider Name: _____

TELEPSYCHOLOGY LOCATION OF MENTAL HEALTH PROVIDER: _____

Patient's preferred method of communication with mental health practitioner (please check one):

_____ Videoconferencing (audio and video via web came) using Zoom

_____ Telephone (audio only, no video)

Please provide telephone number ( ) _____ - _____

Patient Signature: _____ Date: _____
Printed Name: _____ Date: _____
Parent/Guardian Signature, if child: _____ Date: _____
Mental Health Clinician Signature: _____ Date: _____