

## CONSENT FORM

*For Behavioral Health /SUD Tele-Health communications, phone, text messages, audio and email. (ALL forms of communication electronically)*

**Client Name: I,** \_\_\_\_\_, agree to participate in teletherapy with a Counselor of ***Inner Journey Healing Arts Center-Out Patient.***

This means that:

- I authorize information about my medical and mental health care to be transferred electronically through an interactive video connection between Inner Journey Healing Arts Center and client(s).
- I understand that I will be informed of the identities of all people who are present during the teletherapy session and informed of their purpose for attending the session.
- My counselor/Counselor has explained how the teletherapy system works and how it will be used for my treatment.
- My counselor/Counselor has explained how this service will differ from face-to-face sessions, including emotional reactions that may arise due to technology use.
- I understand that my counselor will not be physically present during my teletherapy session. Instead, we will see each other electronically.
- I understand that teletherapy is an evolving modality for therapy. As such, there may be potential risks that may not yet be recognized.
- Potential risks include:
  - a) at times the video image may be unclear or inadequate, b) a disruption in the connection may occur, or c) in rare circumstances, the information may be intercepted by unauthorized persons.
- I authorize the release of information pertaining to me determined by my mental health care providers or by my insurance company for the purpose of processing insurance claims.
- I understand that at any time, I may decide to discontinue teletherapy sessions with my provider. My counselor will refer me to a local mental health provider who can provide face-to-face services.
- I understand that, under the law, my counselor / health provider may be required to report to the authorities any information suggesting that I have engaged in behaviors that are dangerous to myself or others.
- My counselor have explained the risks and benefits of receiving teletherapy. I understand that I still may need to see a specialist in person.
- I understand that information from my teletherapy sessions will be protected by HIPPA privacy laws. I may request a copy of my electronic record in writing.

## CONSENT FORM

*For Behavioral Health /SUD Tele-Health communications, phone, text messages, audio and email. (ALL forms of communication electronically)*

- I understand that as part of receiving teletherapy, some information may / will be used for research purposes. No identifying information will be revealed to anyone other than those involved in OHA/AMH (MOTS), Health Insurance for billing, and UA laboratory. Similar information on original ROI signed at Intake/Assessment.

In response to COVID-19, **Washington County Health Service, CareOregon** is temporarily adjusting telemedicine requirements per CMS and OHA guidance. It is imperative during this public health emergency that members avoid travel, when possible, to providers' offices, clinics, hospitals or other health care facilities, where they could risk their own or others' exposure to further illness. Accordingly, providers may deliver services to members via telephone or telemedicine, in any geographic area and from a variety of places, including members' homes. With this flexibility, members can receive clinically appropriate services without coming into the clinic or office. Operational definition of telemedicine: The use of telephonic or electronic communications of medical information from one site to another regarding a patient's health status, including but not limited to: Patient-to-clinician services via: Clinician-to-clinician consultations via: • Telephone • Telehealth – synchronous audio and video • E-visits (online services) • Telephone • Electronic communication (online services) • Asynchronous e-consults (online services)

Subject: *Expanded telehealth coverage for behavioral health services* As part of Oregon's response to the COVID-19 crisis, the **Oregon Health Authority (OHA)** is working to ensure members of the Oregon Health Plan have continued access to quality behavioral health services. Access to telehealth for behavioral health is necessary during this critical time and providers and plans should expand telehealth opportunities. With ongoing planning around COVID-19, this memo: ■ Clarifies telehealth (including telephone) policies for behavioral health services and ■ Provides information on newly opened codes.

Client Name: \_\_\_\_\_ Date \_\_\_\_\_

Client Signature: \_\_\_\_\_ Date \_\_\_\_\_

Counselor: \_\_\_\_\_ Date \_\_\_\_\_

Parent or Legal Guardian \_\_\_\_\_ Date \_\_\_\_\_