BEA ARMSTRONG, MFT
Licensed Marriage and Family Therapist

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# INFORMED CONSENT

As a client or patient receiving mental health services from Bea Armstrong, MFT, I understand:

These mental health services use interactive technologies (audio, video or other electronic communications) between a practitioner and a client/patient who are not in the same physical location. The interactive technologies used incorporate network and software security protocols to protect the confidentiality of client/patient information transmitted via any electronic channel. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption. Electronic systems used will incorporate network and software security protocols to protect the privacy and security of health information and imaging data, and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption.

1. This service is provided by technology (including but not limited to video, phone, text, apps and email) and may not involve direct face-to-face communication. There are benefits and limitations to this service. I will need access to, and familiarity with, the appropriate technology in order to participate in the service provided. The exchange of information will not be direct and any paperwork exchanged will likely be provided via electronic means or through postal delivery. During my consultation, details of my medical history and personal health information may be discussed with me or other health care professionals through the use of interactive video, audio or other telecommunications technology, but only upon my signing a release of confidentiality.

2. If a need for direct, in-person services arises, it is my responsibility to contact practitioners in my area such as my physician or emergency hospitalization via 911.

3. I may decline any health services at any time without jeopardizing my access to future care, services, and benefits.

4. These services rely on technology, which allows for greater convenience in service delivery. There are risks in transmitting information over technology that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties. My practitioner and I will regularly reassess the appropriateness of continuing to deliver services to me through the use of the technologies we have agreed upon and modify our plan as needed.

5. In emergencies, in the event of disruption of service, or for routine or administrative reasons, it may be necessary to communicate by other means. In this case, a cell phone number has been given to me. Postal letters may also be used.

6. My practitioner will respond to communications and most routine messages within 24 hours.

Add initials here _____ to confirm that you have read this page.

7. It is my responsibility to maintain privacy on the client end of communication. Insurance companies, those authorized by me, the client, and those permitted by law may also have access to records or communications.

8. My communication exchanged with my mental health provider will be stored in the following manner: printed and stored in locked file cabinets in provider's home office.

9. The laws and professional standards that apply to in-person behavioral services also apply to telehealth services. This document does not replace other agreements, contracts, or documentation of informed consent.

_____
Client Printed Name

_____
Client Signature

_____
Date

Bea Armstrong, MFT
Mental Health Professional
License: MFC #30226

_____
Signature of Practitioner

_____
Date

Add initials here _____ to confirm that you have read this page.

## ADDENDUM A

Client/Patient Name: _____

I, the undersigned, a citizen of _____, agree to participate in technology-based consultation and other health care related information exchanges with Bea Armstrong, MFT, a mental health care practitioner. This means that I authorize information related to my medical and behavioral health to be electronically transmitted in the form of images and data through an interactive video connection to and from the above-named practitioner. It may also mean that my private health information may be transmitted from my practitioner's mobile device to my own or from my device to that of my practitioner via an "application" (abbreviated as "app").

I understand that a variety of alternative methods of mental health care may be available to me, and that I may choose one or more of these at any time. My health care professional has explained the alternative to my satisfaction.

I attest that I am using my own equipment to communicate and not equipment owned by another, and specifically not using my employer's computer or network. I am aware that any information I enter into an employer's computer can be considered by the courts to belong to my employer and my privacy may thus be compromised.

I understand that I will be informed of the identities of all parties present during the consultation or who have access to my personal health information and of the purpose for such individuals to have such access.

My health care practitioner has explained how the electronic health consultation is performed and how it will be used for my treatment. My practitioner has also explained how the consultations will differ from in-person services, including but not limited to emotional reactions that may be generated.

I understand that it is my duty to inform my practitioner of electronic interactions regarding my care that I may have with other health care providers.

In brief, I understand that my practitioner will not be physically in my presence. Instead, we will see and hear each other electronically or that other information such as information I enter into an "app" will be transmitted electronically to and from my practitioner and me. Regardless of the sophistication of today's technology, some information my practitioner would ordinarily get in in-person consultation may not be available via teleconsultation. I understand that such missing information could in some situations make it more difficult for my practitioner to understand my problems and to help me get better. My practitioner will be unable to physically touch me or to render any emergency assistance if I experience a crisis.

Add initials here ____ to confirm that you have read this page.

I understand that telehealth is a new delivery method for professional services, in an area not yet fully validated by research, and may have potential risks, possibly including some that are not yet recognized. Among the risks that are recognized is the possibility that the technology will fail before or during the consultation, that the transmitted information in any form will be unclear or inadequate for proper use in the session, and that the information will be intercepted by an unauthorized person or persons.

In rare cases, security protocols could fail, causing a breach of privacy of personal health information. I understand that a physical examination may be performed by individuals at my location at the request of the practitioner.

I authorize the release of any information pertaining to me determined by my practitioner, my other health care practitioners or by my insurance carrier to be relevant to the consultations or processing of insurance claims, including but not limited to my name, Social Security number, birth date, diagnosis, treatment plan and other clinical or medical record information.

I understand that at any time, the session can be discontinued by me or by my designee or by my mental health practitioner. I further understand that I do not have to answer any question that I feel is inappropriate or whose answer I do not wish persons present to hear; that any refusal to participate in the consultation or use of technology will not affect my continued treatment and that no action will be taken against me. I acknowledge, however, that diagnosis depends on information, and treatment depends on diagnosis, so if I withhold information, I assume the risk that a diagnosis might not be made or might be made incorrectly. Were that to happen, my telehealth treatment might be less successful than it otherwise would be, or it could fail entirely.

I also understand that, under the law, and regardless of what form of communication I use in working with my practitioner, my practitioner may be required to report to the authorities information suggesting that I have engaged in behaviors that endanger myself or others.

The alternatives to the consultations have been explained to me, including their risks and benefits, as well as the risks and benefits of doing without treatment. I understand that I can still pursue in-person consultations. I understand that the telehealth consultations do not necessarily eliminate my need to see a specialist in person, and I have received no guarantee as to the telehealth consultation's effectiveness.

I understand that consultations, test results, and disclosures will be held in confidence subject to state and/or federal law. I understand that I am ordinarily guaranteed access to my records and that copies of records of sessions, or summaries thereof, are available to me upon written request. I also understand, however, that if my practitioner, in the exercise of professional judgment, concludes that providing my records to me could threaten the safety of a human being, myself or other, he or she may rightfully decline to provide them. If such a request is made and honored, I understand that I retain sole responsibility for the confidentiality of the records released to me and that I may have to pay a reasonable fee to get a copy or a summary.

Add initials here _____ to confirm that you have read this page.

I have received a copy of my practitioner's contact information, including her name, phone number, voicemail number, business address, mailing address, and email address if applicable (see last page). I have also been provided with a list of local support services in case of an emergency. I am aware that my practitioner may contact the proper authorities and/or my designated, local contact person in case of an emergency.

I acknowledge, however, that if I am facing or if I think I may be facing an emergency situation that could result in harm to me or to another person, I am not to seek a telehealth consultation. Instead I agree to seek immediate care through my own local health care practitioner or the nearest hospital emergency department or by calling 911.

These are the names and phone numbers of my local emergency contacts (including local physician; crisis hotline; and trusted family member, friend or adviser):

Physician: _____ Phone Number: _____

Emergency Crisis Hotline: 855-278-4204 or 911

Family/Friend Name: _____ Phone Number: _____

Relationship: _____

I unconditionally release and discharge Bea Armstrong, MFT, from any liability in connection with my participation in the remote consultations/sessions.

I have read this document carefully and fully understand the benefits and risks. I have had the opportunity to ask any questions I have and have received satisfactory answers. With this knowledge, I voluntarily consent to participate in the telehealth consultations/sessions, including but not limited to any care, treatment, and services deemed necessary and advisable under the terms described herein.

_____ _____

Name Date

Add initials here ____ to confirm that you have read this page.

**Practitioner's Information Page**

Bea Armstrong, MFT

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San Jose, CA 95117

Mailing Address:
Same as above

Voice Mail: 408-486-9202

Email: bea@beaarmstrong.com
therapist@beaarmstrong.com

Website: http://beaarmstrong.com

CA License: MFC 30226

CRISIS NUMBERS: 855-278-4204 or 911

ALSO SEE LIST OF EMERGENCY NUMBERS ON MY WEBSITE.