

Tele-behavioral Health/Walk and Talk Informed Consent

Name of Client/Patient: _____

Electronic Transmission of Information

I, the undersigned, or my designee(s), on my behalf, agree to participate in technology-based consultation and other healthcare-related information exchanges with Chris Quaglino, LCSW, LCDC, a behavioral 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, other persons involved in my health care, and the staff operating the consultation equipment.

Meeting in Public Spaces

I understand that meeting in public places incurs risks of being seen or heard. This is either walking and talking, or meeting at a park. I further understand that Chris Quaglino may stop a session if the work we are doing becomes emotional in nature, as not to be appropriate for an outdoor setting. I further understand that I we may run into person(s) whom may know one or both of us and we will acknowledge them if they acknowledge us first and not engage in conversation with them. And finally, I understand that the decision to participate in outdoor sessions is always optional and that I can stop any session immediately and/or request we meet inside of an office or online for any and all future sessions.

Mobile Application

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 or app. I understand that a variety of alternative methods of behavioral health care may be available to me, and that I may choose one or more of these at any time. My behavioral health care provider has alternatives to my satisfaction.

Equipment

I represent that **I will use my own equipment to communicate** during my session(s) and **not equipment owned by another, and specifically I will not ever use 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.**

Identification

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.

Tele-behavioral Health Process

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

Additional Services

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.

Electronic Presence

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 myself and my practitioner.

Limitations

Regardless of the sophistication of today's technology, some information my practitioner would ordinarily get in in-person consultation may not be available in 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.

Risks

I understand that tele-behavioral health 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 presently 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 consultation(s), and that the information will be intercepted by an unauthorized person or persons. In rare instances, 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 consulting practitioner.

Release of Information

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 consultation(s) 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.

Discontinuing Care

I understand that at any time, the consultation(s) can be discontinued either by me or by my designee or by my health care practitioners. 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(s) 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-based treatment might be less successful than it otherwise would be, or it could fail entirely.

Limits of Confidentiality

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 authority's information suggesting that I have engaged in behaviors that pose an imminent threat of harm to myself or will endanger others.

Alternatives

The alternatives to the consultation(s) 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 tele-behavioral health consultation(s) does not necessarily eliminate my need to see a specialist in person, and I have received no guarantee as to the Tele-behavioral consultation's effectiveness.

Records

I understand that my tele-behavioral consultation(s) may be recorded and stored electronically as part of my medical records. I will be notified at the time the reason(s) for recording or storing my session(s) before this occurs. 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 consultation(s) are available to me on my 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 another person, 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.

Contact Information

I have received a copy of my practitioner's contact information, including his or her name, telephone number, pager and/or voice mail number, business address, mailing address, and e-mail address (if applicable). 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.

Emergency Care

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 tele-behavioral consultation. Instead, I agree to seek care immediately through my own local health care practitioner or at the nearest hospital emergency department or by calling 911. I will also utilize the resources in the

Crisis or Emergency section of Tele-behavioral Health Informed Consent form.

Release of Liability

I unconditionally release and discharge Chris Quaglino, LCSW, LCDC from any liability in connection with my participation in the remote consultation(s). Including Walk and Talk, as well as , Teletherapy.

Final Agreement

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 tele-behavioral consultation(s), including but not limited to any care, treatment, and services deemed necessary and advisable, under the terms described herein.

Confirmation of Agreement

By signing below, the client acknowledges the receipt of this Tele-behavioral Health Informed Consent.

I also agree not to share the sessions I have with Chris Quaglino, LCSW, LCDC through any type of media in any format (this includes, but is not limited to, any form of social media, email, data transfer or allowing others to view my sessions in real time or recorded). I also acknowledge that Chris Quaglino, LCSW, LCDC highly recommends that I do not record my sessions so the risk of my accidental release of personal information is greatly reduced.

Client Name (please print)

Client Signature (or authorized representative*)

Date

* If signed by an individual other than the client, please indicate the relationship between client and their representative:
