- Cristina Panaccione And Associates, LLC
- 5168 Campbells Run Rd Suite 204
- Pittsburgh, Pa 15205
- (412) 439-1416

Telemental Health Informed Consent

Introduction of Telemental Health

Telemental health is the delivery of behavioral health services using interactive technologies (use of audio, video or other electronic communications) between a clinician/therapist and a client who are not in the same physical location. These services may include apps and links you may not be familiar with, please discuss your concerns with your therapist/clinician.

I agree to identify my location to my therapist and to assure my space is secure, confidential and without interruptions during our session.

As your clinician/therapist, I may determine that due to certain circumstances, telemental health services is no longer appropriate and that we should resume our sessions in-person, when permitted to do so.

Laws & Standards

The laws and professional standards that apply to in-person behavioral services also apply to telemental health services. This document does not replace other agreements, contract, or documentation of informed consent. You may be also be asked to provide verbal consent and identifying information at the beginning of each telemental health session.

Software Security Protocols/ Risk

I understand that telemental 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. At times, the technology may fail before or during the session, the transmission may sometimes be unclear or inadequate for proper use.

I understand that my telemental health consultation may be recorded and stored electronically. These interactive services incorporate network software security protocols to protect confidentiality of information transmitted via any electronic device. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption.

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 services. I hereby authorize these disclosures to take place without prior written consent.

Exchange of Information

During my telemental health consultation, details of my personal/medical history information may be collected. For the purpose of collaboration and referral this information may also be discussed with other behavioral health care professionals using interactive video, audio or other telecommunications technology.

Self-Termination/ Payment for services/ Cancellation Policy

I may decline any telemental health services at any time without jeopardizing my access to future care, services, and face to face visits in the future. It is important to be on time. I Understand I will be billed a **late cancelation/ no show fee of $75.00** if I miss or fail to cancel an appointment without providing at least 24 hours' notice.

Please confirm with your insurance company that the video sessions/ calls will be reimbursed; if they are not; you may be responsible for full payment.

EMERGENCY CARE

I acknowledge, 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 telemental health services. Instead, I agree to seek care immediately through my own local health care provider or at the nearest hospital emergency department or by calling 911. I also have access to the emergency National Suicide Hotline at 800-784-2433.

If you need to speak to your clinician/therapist between sessions, please contact them directly at the number provided upon scheduling or leave a message on the main line at 412-439-1416. Your call will be returned as soon as possible. Messages are checked during the daytime hours and less frequently during the weekends or holidays.

Emergency Contact Information

I agree to provide at least one person my clinician/therapist can contact in the event of an emergency situation or who can conduct a wellness check on me.

Name: _____ Telephone Number _____

Final Agreement

I have read this document carefully and fully understand the benefits and risks. I have had the opportunity to ask any question I have and have received satisfactory answers. With this knowledge, I voluntarily (in writing and/or verbally) consent to participate in telemetnal health services. I agree to unconditionally release and discharge Cristina Panaccione and Associates, including my clinician/therapist, from any liability in connection with my participation in the remote sessions.

Name: _____DOB: _____Date: _____

Consent to treat a minor: The above release is given on behalf of _____, DOB _____.