MERIDIAN COUNSELING SERVICES

TELEHEALTH INFORMED CONSENT

I hereby consent to engaging in telehealth via Simple Practice and/or Zoom with Meridian Counseling Services. I understand that "telehealth" includes the practice of health care assessment, diagnosis, consultation, treatment and psychoeducation using interactive audio, video, or data communications. I understand that using the Telehealth platform allows me to have access to mental health services that might not otherwise be available to me due to a variety of circumstances.

CONSENT TO PARTICIPATE IN TELETHERAPY

1. I understand that teletherapy is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations. In this case, the technology used is a secure video session via Zoom Video Communications. I understand it is strongly advised that I consider the location of engaging in a telehealth session; preferably in a secure room without anyone else present as a way to protect my privacy around the sensitive information discussed.
2. I understand that I will need to have a broadband Internet connection or a smartphone device with a good cellular connection at home or at the location deemed appropriate for services. I also understand that in case of technology failure, I may contact my therapist via phone to coordinate alternative methods of treatment.
3. I understand that there are both benefits and risks associated with teletherapy, including but not limited to, disruption by technology failures, interruption and/or breaches by unauthorized persons, and/or limited ability to respond to emergencies. In addition, I understand that telehealth- based services and care may not be as beneficial as face-to-face services. I also understand that if my therapist believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services) I will be referred to a counselor/therapist who can provide such services in my geographic area.
4. I understand that my healthcare provider or I can discontinue the use of teletherapy for therapy sessions if it is felt that the videoconferencing connections are not adequate for the situation.
5. I understand that I may benefit from telehealth but that results cannot be guaranteed or assured.
6. I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.
7. I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to teletherapy unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).

CONSENT TO USE THE TELEHEALTH BY SIMPLEPRACTICE SERVICE

Telehealth by SimplePractice and/or Zoom are HIPAA compliant technology services that may be used to conduct telehealth videoconferencing appointments. They are simple to use and there are no passwords required to log in. By signing this document, I acknowledge:

1. Telehealth by SimplePractice and Zoom are NOT Emergency Services and in the event of an emergency, I will use a phone to call 911.
2. Though my provider and I may be in direct, virtual contact through the Telehealth Service, neither SimplePractice, Zoom, nor the Telehealth Service provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
3. The Telehealth by SimplePractice or Zoom Service facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.
4. I do not assume that my provider has access to any or all of the technical information in the Telehealth by SimplePractice Service or Zoom – or that such information is current, accurate or up-to-date. I will not rely on my health care provider to have any of this information in the Telehealth by SimplePractice or Zoom Service.

5. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

OUT OF STATE TRAVEL

By signing this form, I acknowledge that I am aware that I am working with a therapist at Meridian Counseling Services, who is a licensed counselor and/or therapist practicing in Washington State. Given this, I understand that my therapist would not be subject to out-of-state rule or regulations. I am aware that my therapist was trained and continues to practice under the regulatory codes of Washington State (Chapter 18.225 RCW). All ethical concerns are also governed by the state of Washington (Chapter 246-809 WAC).

Furthermore, I understand the benefits and limitations associated with temporarily continuing care while out-of-state and I agree to seek out higher levels of local support and/or crisis support if needed. This may include but is not limited to calling or texting the suicide and crisis lifeline at 988 or chatting this service at 988lifeline.org

Financial Obligations

Fees associated with telehealth appointments are the same as “in office” appointments and are payable by credit, debit, or HSA card. The card fee is $170 for 50 minute sessions, $255 for 75 minute sessions, and $55 for group sessions. I agree to have my credit/debit/HSA card information on file with Meridian Counseling Services and I give my consent for my card to be charged for my telehealth sessions.

Cancellations

I understand that the Meridian Counseling Services 48 hour cancellation policy applies to telehealth, and I agree to pay for any appointment that I miss or cancel within that 48 hour window.

I understand that I have the following rights with respect to telehealth

1. I have the right to withdraw my consent at any time. 2. I understand that I have a right to access my mental health information and copies of medical records in accordance with Washington state law.

I have read and understand the information provided above. As part of this, I’ve had the opportunity to bring up any questions or concerns I have regarding this consent form and I’ve had them addressed to my satisfaction.

I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Printed Name ____

Signature ____ Date ________________