



Potomac Center, Inc.
5500 Holmes Run Pkwy, Ste C4
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Tel: 703-379-7350

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Telemental Health Informed Consent

Patient Name: _____

Email: _____

DOB: _____

As a client receiving behavioral services through telehealth methods, I understand: Telemental health is the delivery of behavioral health services using interactive technologies (audio, video or other electronic communications) between a provider and a client that are not in the same physical location. The interactive technologies used in Telemental health incorporate network and software security protocols to protect the confidentiality of 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 (included but not limited to video, phone, text and email) and may 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 through electronic means or through postal delivery. During your virtual care consultation, details of your medical history and personal health information may be discussed with you or your behavioral health care professionals through the use of interactive video, audio or other telecommunications technology.

I have read and understand and agree to the terms. Patient signature: _____

2. If a need for direct, face to face services arises, it is my responsibility to contact my behavioral health practitioner's office for a face to face appointment or my primary care provider if my behavioral health practitioner is unavailable. I understand that an opening may not be immediately available in either office.

I have read and understand and agree to the terms. Patient signature: _____

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

I have read and understand and agree to the terms. Patient signature: _____

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 today, and modify our plan as needed.

I have read and understand and agree to the terms. Patient signature: _____

5. In emergencies, in the event of disruption of services, or for routine or administrative reasons, it may be necessary to communicate by other means:

- a. In emergency situations: By phone or by any means deemed necessary at the time
- b. Service disruption: By Phone or email
- c. For other communication: As deemed necessary

I have read and understand and agree to the terms. Patient signature: _____



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6. My practitioner may utilize alternative means of communication in the following circumstances: video connections fail or phone line access is disrupted.

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7. My practitioner or office staff will respond to communications and routine messages within 48 hours on business days or on the next business day following weekends, holidays, or vacations.

I have read and understand and agree to the terms. Patient signature: _____

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

I have read and understand and agree to the terms. Patient signature: _____

9. I will take the following precautions to ensure that my communications are directed only to my behavioral health practitioner or other designated individuals: Double check email addresses; double check phone numbers; double check to whom email is sent (reply vs reply all).

I have read and understand and agree to the terms. Patient signature: _____

10. My communication with my behavioral health practitioner will be stored in the following manner: In compliance with HIPAA regulations in secured file cabinets and/or secured electronic medical record files.

I have read and understand and agree to the terms. Patient signature: _____

11. 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.

I have read and understand and agree to the terms. Patient signature: _____

Patient Consent To The Use of Telemedicine:

I have read and understand the information provided above regarding telemedicine, have discussed it with my provider or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine for my care.

I hereby authorize Potomac Center Inc. and my therapist to use telemedicine in the course of my diagnosis and treatment.

Signature of Patient (or person authorized to sign for patient): _____

Printed name of Patient: _____

Date: _____

If authorized signer, relationship to patient: _____