Informed Consent Teletherapy Addendum

For nearly 60 years, Samaritan Center of Puget Sound has been committed to providing affordable, accessible care which is relational, welcoming, and spiritually grounded. While this traditionally involved face-to-face encounters between clinicians and clients, advances in technology have made it possible to provide therapeutic services remotely through the use of interactive videoconferencing or teletherapy when appropriate. By expanding our services to include teletherapy, Samaritan Center hopes to increase access to care and reduce barriers to treatment (e.g. transportation issues, stigma, underserved areas, lack of qualified clinicians, etc.).

Your therapist, _____, offers teletherapy services in Washington State. These services are offered for clients who possess barriers to usual care that occurs in the clinician's office. Samaritan Center clinicians use a teletherapy program that is designed to provide a more secure platform and infrastructure than more commonly used consumer services (e.g., Skype, Google Hangout, FaceTime, etc.). This teletherapy product encrypts the information before transmitting it over the Internet. The company offering this product offers security measures to help guard against threats to information security. However, any time information is communicated over the Internet, even in an encrypted form, there is a risk to information security, client confidentiality, and privacy. Clients who use teletherapy must carefully weigh the benefits (e.g., convenience, access to care) with the risks (e.g., risks to privacy and confidentiality, diminished ability to respond to emergencies compared to visits in the office).

In accordance with Samaritan Center policy, your therapist will meet with you 1 to 3 times in order to conduct an intake session and establish a therapeutic relationship. At the end of the intake process, you and your therapist will discuss whether teletherapy is an appropriate treatment modality. Clients seen via teletherapy may request to be seen in-person at any time during the course of treatment; the therapist will provide appropriate referrals if they are unable to accommodate this request.

During your initial intake and treatment planning sessions, your therapist will establish a teletherapy safety plan with you. Your therapist will review the address and telephone number where you will receive care; in addition, you will be asked to identify local emergency services and their contact information. You will also be given an opportunity to identify and sign a release of information for a client support person (CSP), someone who may be contacted in case of emergency. Please note, a CSP is not required and you may decline to designate an outside party as a CSP.

Your therapist recommends teletherapy for clients without frequent emergency management (e.g., hospitalization) needs. If you are experiencing an emergency (e.g., considering harm to yourself or others) during a teletherapy therapy session, your therapist will determine whether to contact your CSP or local emergency services.

Your therapist meets with teletherapy clients during their scheduled appointment times, is not available for unscheduled teletherapy meetings, and will not answer teletherapy calls made outside the mutually agreed upon appointment time.

At times, teletherapy may suffer technological disruptions. It is possible that a session could be disrupted due to problems related to computer hardware, teletherapy programs, Internet connectivity, etc. In case of teletherapy technology disruption, your therapist will attempt to reestablish connection for a reasonable amount of time. Then, your therapist will attempt to contact you by other means (first by phone, then email, then a mailed letter) in order to reschedule teletherapy services.

Please note that clients are responsible to pay for sessions disrupted by technology. Please also note that insurance may or may not cover sessions interrupted by technology.

Your therapist is licensed to practice in the state of Washington and is typically not permitted to practice outside these jurisdictional boundaries, even with telehealth. This means that your therapist is typically not permitted to serve clients when they are traveling out of state. If you are participating in telehealth sessions, it is your responsibility to inform your therapist if you have travelled outside the state of Washington.

At any time, your therapist or you may determine that teletherapy is no longer appropriate for your care. Your therapist will make best efforts to accommodate treatment needs in person; if this is not possible, you will be provided with referrals for other providers.

I consent to teletherapy: _____ (Client #1 Initials)

I consent to teletherapy: _____ (Client #2 Initials)

I consent to teletherapy: _____ (Client #3 Initials)

I consent to teletherapy: _____ (Client #4 Initials)

Informed Consent for Telephone Therapy and Communication using Telephone:
When therapy is conducted over the telephone (VOIP, mobile phones and landlines), your confidentiality is at higher risk of being compromised than in-person.

I consent to telephone communication: _____ (Client #1 Initials)

I consent to telephone communication: _____ (Client #2 Initials)

I consent to telephone communication: _____ (Client #3 Initials)

I consent to telephone communication: _____ (Client #4 Initials)

Financial Information Related to Technology
Please note that your therapist charges for missed sessions, as well as sessions cancelled less than 24 hours prior to the commencement of a scheduled appointment. **Clients are responsible for fees related to sessions interrupted (e.g., not completed) due to technology problems.**

Client #1 Teletherapy Intake Addendum

Instructions: Please fill out this intake questionnaire as best as you are able and return to your therapist.

Client #1 Clinical Assessment:

Teletherapy services at Samaritan Center typically begin in non-crises. When clients in teletherapy require additional crisis support, they may be asked to meet in person with their therapist.

1. Are you seeking therapy services for a crisis in your life? ☐ **Yes** ☐ **No**
2. Do you currently have, or have you had in the past 12 weeks, ideas, plans or thoughts about hurting yourself? ☐ **Yes** ☐ **No**
3. About hurting someone else? ☐ **Yes** ☐ **No**
4. Have you ever been hospitalized for emotional health reasons? ☐ **Yes** ☐ **No**
    a. If yes, when?
    b. What happened?

5. Is this issue related to an accident or legal action that is pending? ☐ **Yes** ☐ **No**
    a. Are you seeking an assessment related to legal action? ☐ **Yes** ☐ **No**
6. Please describe your access to firearms:

Client #1 Technical Assessment:

1. Do you have access to a computer or mobile device? ☐ **Yes** ☐ **No**
    a. What kind:
    b. Is your computer/profile password protected? ☐ **Yes** ☐ **No**
2. Do you have a camera built into your device? ☐ **Yes** ☐ **No**
3. Do you have Internet: ☐ **Yes** ☐ **No**
    a. What kind:
4. Do you have WiFi? ☐ **Yes** ☐ **No**

a. Is it password protected? ☐ **Yes** ☐ **No**

b. Is the network visible to the public? ☐ **Yes** ☐ **No**

5. Do you have telephone service? ☐ **Yes** ☐ **No**

   a. What kind:

   b. Do you share your telephone with anyone? ☐ **Yes** ☐ **No**

   c. If a mobile device or VoIP, is it password protected? ☐ **Yes** ☐ **No**

6. Do you have an email account? ☐ **Yes** ☐ **No**

   a. Is it password protected with a robust password: ☐ **Yes** ☐ **No**

   b. Do you share the account/ its password with anyone: ☐ **Yes** ☐ **No**

7. Have you ever used a videoconferencing program? ☐ **Yes** ☐ **No**

   a. What was your experience of it?

8. What questions do you have about teletherapy/videoconferencing?

9. What reservations do you have?

Client #2 Teletherapy Intake Addendum

Instructions: Please fill out this intake questionnaire as best as you are able and return to your therapist.

Client #2 Clinical Assessment:

Teletherapy services at Samaritan Center typically begin in non-crises. When clients in teletherapy require additional crisis support, they may be asked to meet in person with their therapist.

1. Are you seeking therapy services for a crisis in your life? ☐ **Yes** ☐ **No**
2. Do you currently have, or have you had in the past 12 weeks, ideas, plans or thoughts about hurting yourself? ☐ **Yes** ☐ **No**
3. About hurting someone else? ☐ **Yes** ☐ **No**
4. Have you ever been hospitalized for emotional health reasons? ☐ **Yes** ☐ **No**
    a. If yes, when?
    b. What happened?

5. Is this issue related to an accident or legal action that is pending? ☐ **Yes** ☐ **No**
    a. Are you seeking an assessment related to legal action? ☐ **Yes** ☐ **No**
6. Please describe your access to firearms:

Client #2 Technical Assessment:

☐ **Check here if information matches Client #_____'s Technical Assessment; if so, proceed to p. 7**

1. Do you have access to a computer or mobile device? ☐ **Yes** ☐ **No**
    a. What kind:
    b. Is your computer/profile password protected? ☐ **Yes** ☐ **No**
2. Do you have a camera built into your device? ☐ **Yes** ☐ **No**
3. Do you have Internet: ☐ **Yes** ☐ **No**
    a. What kind:
4. Do you have WiFi? ☐ **Yes** ☐ **No**

a. Is it password protected? ☐ **Yes** ☐ **No**

b. Is the network visible to the public? ☐ **Yes** ☐ **No**

5. Do you have telephone service? ☐ **Yes** ☐ **No**

   a. What kind:

   b. Do you share your telephone with anyone? ☐ **Yes** ☐ **No**

   c. If a mobile device or VoIP, is it password protected? ☐ **Yes** ☐ **No**

6. Do you have an email account? ☐ **Yes** ☐ **No**

   a. Is it password protected with a robust password: ☐ **Yes** ☐ **No**

   b. Do you share the account/ its password with anyone: ☐ **Yes** ☐ **No**

7. Have you ever used a videoconferencing program? ☐ **Yes** ☐ **No**

   a. What was your experience of it?

8. What questions do you have about teletherapy/videoconferencing?

9. What reservations do you have?

Client #3 Teletherapy Intake Addendum

Instructions: Please fill out this intake questionnaire as best as you are able and return to your therapist.

Client #3 Clinical Assessment:

Teletherapy services at Samaritan Center typically begin in non-crises. When clients in teletherapy require additional crisis support, they may be asked to meet in person with their therapist.

1. Are you seeking therapy services for a crisis in your life? ☐ **Yes** ☐ **No**
2. Do you currently have, or have you had in the past 12 weeks, ideas, plans or thoughts about hurting yourself? ☐ **Yes** ☐ **No**
3. About hurting someone else? ☐ **Yes** ☐ **No**
4. Have you ever been hospitalized for emotional health reasons? ☐ **Yes** ☐ **No**
    a. If yes, when?
    b. What happened?

5. Is this issue related to an accident or legal action that is pending? ☐ **Yes** ☐ **No**
    a. Are you seeking an assessment related to legal action? ☐ **Yes** ☐ **No**
6. Please describe your access to firearms:

Client #3 Technical Assessment:

☐ **Check here if information matches Client #_____'s Technical Assessment; if so, proceed to p. 9**

1. Do you have access to a computer or mobile device? ☐ **Yes** ☐ **No**
    a. What kind:
    b. Is your computer/profile password protected? ☐ **Yes** ☐ **No**
2. Do you have a camera built into your device? ☐ **Yes** ☐ **No**
3. Do you have Internet: ☐ **Yes** ☐ **No**
    a. What kind:
4. Do you have WiFi? ☐ **Yes** ☐ **No**

a. Is it password protected? ☐ **Yes** ☐ **No**

b. Is the network visible to the public? ☐ **Yes** ☐ **No**

5. Do you have telephone service? ☐ **Yes** ☐ **No**

   a. What kind:

   b. Do you share your telephone with anyone? ☐ **Yes** ☐ **No**

   c. If a mobile device or VoIP, is it password protected? ☐ **Yes** ☐ **No**

6. Do you have an email account? ☐ **Yes** ☐ **No**

   a. Is it password protected with a robust password: ☐ **Yes** ☐ **No**

   b. Do you share the account/ its password with anyone: ☐ **Yes** ☐ **No**

7. Have you ever used a videoconferencing program? ☐ **Yes** ☐ **No**

   a. What was your experience of it?

8. What questions do you have about teletherapy/videoconferencing?

9. What reservations do you have?

Client #4 Teletherapy Intake Addendum

Instructions: Please fill out this intake questionnaire as best as you are able and return to your therapist.

Client #4 Clinical Assessment:

Teletherapy services at Samaritan Center typically begin in non-crises. When clients in teletherapy require additional crisis support, they may be asked to meet in person with their therapist.

1. Are you seeking therapy services for a crisis in your life? ☐ **Yes** ☐ **No**
2. Do you currently have, or have you had in the past 12 weeks, ideas, plans or thoughts about hurting yourself? ☐ **Yes** ☐ **No**
3. About hurting someone else? ☐ **Yes** ☐ **No**
4. Have you ever been hospitalized for emotional health reasons? ☐ **Yes** ☐ **No**
    a. If yes, when?
    b. What happened?

5. Is this issue related to an accident or legal action that is pending? ☐ **Yes** ☐ **No**
    a. Are you seeking an assessment related to legal action? ☐ **Yes** ☐ **No**
6. Please describe your access to firearms:

Client #4 Technical Assessment:

☐ **Check here if information matches Client #_____'s Technical Assessment; if so, proceed to p. 11**

1. Do you have access to a computer or mobile device? ☐ **Yes** ☐ **No**
    a. What kind:
    b. Is your computer/profile password protected? ☐ **Yes** ☐ **No**
2. Do you have a camera built into your device? ☐ **Yes** ☐ **No**
3. Do you have Internet: ☐ **Yes** ☐ **No**
    a. What kind:
4. Do you have WiFi? ☐ **Yes** ☐ **No**

a. Is it password protected? ☐ **Yes** ☐ **No**

b. Is the network visible to the public? ☐ **Yes** ☐ **No**

5. Do you have telephone service? ☐ **Yes** ☐ **No**

   a. What kind:

   b. Do you share your telephone with anyone? ☐ **Yes** ☐ **No**

   c. If a mobile device or VoIP, is it password protected? ☐ **Yes** ☐ **No**

6. Do you have an email account? ☐ **Yes** ☐ **No**

   a. Is it password protected with a robust password: ☐ **Yes** ☐ **No**

   b. Do you share the account/ its password with anyone: ☐ **Yes** ☐ **No**

7. Have you ever used a videoconferencing program? ☐ **Yes** ☐ **No**

   a. What was your experience of it?

8. What questions do you have about teletherapy/videoconferencing?

9. What reservations do you have?

Samaritan
Center of Puget Sound

Teletherapy Emergency Plan

Receiving behavioral health services remotely has advantages (i.e., helping clients access care unavailable locally), but also has limitations and risks. The therapist's ability to respond to a medical or psychiatric emergency may be impacted. The following plan for emergency management is an effort to mitigate some of these risks. If you will be participating in couples therapy from the same location as your partner, you may complete this section as a couple.

Please complete the following information for each location teletherapy will occur.

Your name(s): _____

Address where care occurs: _____

Telephone number where care occurs: _____

Alternate number: _____

Telephone number for local emergency services: _____

Second location (complete only if applicable):

Your name(s): _____

Address where care occurs: _____

Telephone number where care occurs: _____

Alternate number: _____

Telephone number for local emergency services: _____

Third location (complete only if applicable):

Your name(s): _____

Address where care occurs: _____

Telephone number where care occurs: _____

Alternate number: _____

Telephone number for local emergency services: _____

Teletherapy Emergency Plan Continued

Fourth location (complete only if applicable):

Your name(s): _____

Address where care occurs: _____

Telephone number where care occurs: _____

Alternate number: _____

Telephone number for local emergency services: _____

What to Expect in an Emergency:

In case of behavioral/medical emergency, the therapist will attempt to contact emergency services in your local area. Examples of emergencies could include a client communicating intent to harm self or another, a medical emergency, or any other condition requiring medical or psychiatric attention. The therapist will try to keep communication with you, while they call for help. This may mean that the paramedics, mental health professionals or local police would come to your location to ensure that you are well. If appropriate, the therapist will also contact your support person.

In case of videoconferencing failure, the therapist will contact the client using the telephone. In case of telephone failure (and without safety concern), the therapist would use secure messaging, secure email, or another agreed upon communication format.

Please sign below to confirm your understanding of the emergency plan.

Client #1 Signature: _____

Client #2 Signature: _____

Client #3 Signature: _____

Client #4 Signature: _____

Teletherapy Emergency Plan Continued

Community Support Person (CSP): If you are participating in teletherapy, particularly as an individual, you may want to consider identifying a CSP who could be contacted in case of emergencies. A CSP is someone who is aware that you are in therapy and is accessible to you (nearby, willing to help) during your videoconferencing therapy session. You are not required to identify a CSP and may decline to fill out the remainder of this form. If you do choose to identify a CSP you will need to sign a release of information (see p. 14-17) to allow your therapist to contact this person.

Client #1's CSP name: _____ Phone #: _____

I give my consent for my therapist to contact my support person. I understand that this means that my therapist may disclose private and confidential information in doing so.

_____ (Client #1 Initials)

Client #2's CSP name: _____ Phone #: _____

I give my consent for my therapist to contact my support person. I understand that this means that my therapist may disclose private and confidential information in doing so.

_____ (Client #2's Initials)

Client #3's CSP name: _____ Phone #: _____

I give my consent for my therapist to contact my support person. I understand that this means that my therapist may disclose private and confidential information in doing so.

_____ (Client #3's Initials)

Client #4's CSP name: _____ Phone #: _____

I give my consent for my therapist to contact my support person. I understand that this means that my therapist may disclose private and confidential information in doing so.

_____ (Client #4's Initials)

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564 NE Ravenna Boulevard * Seattle, Washington 98115 * (206) 527-2266

Authorization to Release/Obtain/Exchange Information

Client #1 Name: _____ Date of Birth: _____

I authorize _____ and Samaritan Center of Puget Sound to
Therapist

☐ **Exchange Information With**

☐ **Obtain Information From**

☐ **Release Information To**

Organization/Individual: (Name of Client #1's Community Support Person designated on p. 13)

Address: _____

Phone #: _____ Fax #: _____

Release the following information:

_____ Health care information relating to the following treatment or condition:

_____

_____ Health care information for the date(s) below:

_____

_____ All health care information:_____

__✔__ Other Community Support Person

This authorization ends:_____ in 180 Days; or __✔__ when the following occurs:

teletherapy concludes

I may cancel this authorization in writing as allowed by law. This would not affect any actions already taken based upon my original request. There are three ways to cancel this authorization:

1) Sign and date a revocation form. This form is available from Samaritan Center of Puget Sound; or
2) Write, sign and date a letter to the Samaritan center of Puget Sound to cancel the authorization; or
3) Sign, date and write "CANCEL" on this original form

Once Samaritan Center of Puget Sound gives out the information, Samaritan Center of Puget Sound has no control over it. The recipient might redisclose it. Privacy laws may no longer protect it.

I also agree to the release of health care information regarding testing, diagnosis, and/or treatment for:

☐ HIV (AIDS virus)
☐ Sexually transmitted diseases
☐ Psychiatric disorders/mental health
☐ Drug and/or alcohol use.

_____ _____ _____
Client #1 Signature Date Time

_____
Relationship to patient if signed on behalf of the patient by parent, legal guardian, personal representative, etc.

Please Note: You have the right to refuse to sign this form. We will not condition treatment on the completion of this authorization.

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564 NE Ravenna Boulevard * Seattle, Washington 98115 * (206) 527-2266

Authorization to Release/Obtain/Exchange Information

Client #2 Name: _____ Date of Birth: _____

I authorize _____ and Samaritan Center of Puget Sound to
Therapist

☐ **Exchange Information With**

☐ **Obtain Information From**

☐ **Release Information To**

Organization/Individual: (Name of Client #2's Community Support Person designated on p. 13)

Address: _____

Phone #: _____ Fax #: _____

Release the following information:

_____ Health care information relating to the following treatment or condition:

_____

_____ Health care information for the date(s) below:

_____

_____ All health care information:_____

✔ Other Community Support Person

This authorization ends: _____ in 180 Days; or ✔ when the following occurs:

teletherapy concludes

I may cancel this authorization in writing as allowed by law. This would not affect any actions already taken based upon my original request. There are three ways to cancel this authorization:

1) Sign and date a revocation form. This form is available from Samaritan Center of Puget Sound; or
2) Write, sign and date a letter to the Samaritan center of Puget Sound to cancel the authorization; or
3) Sign, date and write "CANCEL" on this original form

Once Samaritan Center of Puget Sound gives out the information, Samaritan Center of Puget Sound has no control over it. The recipient might redisclose it. Privacy laws may no longer protect it.

I also agree to the release of health care information regarding testing, diagnosis, and/or treatment for:

☐ HIV (AIDS virus)
☐ Sexually transmitted diseases
☐ Psychiatric disorders/mental health
☐ Drug and/or alcohol use.

_____ _____ _____
Client #2 Signature Date Time

_____
Relationship to patient if signed on behalf of the patient by parent, legal guardian, personal representative, etc.

Please Note: You have the right to refuse to sign this form. We will not condition treatment on the completion of this authorization.

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Authorization to Release/Obtain/Exchange Information

Client #3 Name: _____ Date of Birth: _____

I authorize _____ and Samaritan Center of Puget Sound to
Therapist

☐ **Exchange Information With**

☐ **Obtain Information From**

☐ **Release Information To**

Organization/Individual: (Name of Client #3's Community Support Person designated on p. 13)

Address: _____

Phone #: _____ Fax #: _____

Release the following information:

_____ Health care information relating to the following treatment or condition:

_____

_____ Health care information for the date(s) below:

_____

_____ All health care information:_____

✔ Other Community Support Person

This authorization ends: _____ in 180 Days; or ✔ when the following occurs:

teletherapy concludes

I may cancel this authorization in writing as allowed by law. This would not affect any actions already taken based upon my original request. There are three ways to cancel this authorization:

1) Sign and date a revocation form. This form is available from Samaritan Center of Puget Sound; or
2) Write, sign and date a letter to the Samaritan center of Puget Sound to cancel the authorization; or
3) Sign, date and write "CANCEL" on this original form

Once Samaritan Center of Puget Sound gives out the information, Samaritan Center of Puget Sound has no control over it. The recipient might redisclose it. Privacy laws may no longer protect it.

I also agree to the release of health care information regarding testing, diagnosis, and/or treatment for:

☐ HIV (AIDS virus)
☐ Sexually transmitted diseases
☐ Psychiatric disorders/mental health
☐ Drug and/or alcohol use.

_____ _____ _____
Client #3 Signature Date Time

_____
Relationship to patient if signed on behalf of the patient by parent, legal guardian, personal representative, etc.

Please Note: You have the right to refuse to sign this form. We will not condition treatment on the completion of this authorization.

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Authorization to Release/Obtain/Exchange Information

Client #4 Name: _____ Date of Birth: _____

I authorize _____ and Samaritan Center of Puget Sound to
Therapist

☐ **Exchange Information With**

☐ **Obtain Information From**

☐ **Release Information To**

Organization/Individual: (Name of Client #4's Community Support Person designated on p. 13)

Address: _____

Phone #: _____ Fax #: _____

Release the following information:

_____ Health care information relating to the following treatment or condition:

_____

_____ Health care information for the date(s) below:

_____

_____ All health care information:_____

✔ Other Community Support Person

This authorization ends: _____ in 180 Days; or ✔ when the following occurs:

teletherapy concludes

I may cancel this authorization in writing as allowed by law. This would not affect any actions already taken based upon my original request. There are three ways to cancel this authorization:

1) Sign and date a revocation form. This form is available from Samaritan Center of Puget Sound; or
2) Write, sign and date a letter to the Samaritan center of Puget Sound to cancel the authorization; or
3) Sign, date and write "CANCEL" on this original form

Once Samaritan Center of Puget Sound gives out the information, Samaritan Center of Puget Sound has no control over it. The recipient might redisclose it. Privacy laws may no longer protect it.

I also agree to the release of health care information regarding testing, diagnosis, and/or treatment for:

☐ HIV (AIDS virus)
☐ Sexually transmitted diseases
☐ Psychiatric disorders/mental health
☐ Drug and/or alcohol use.

_____ _____ _____
Client #4 Signature Date Time

_____
Relationship to patient if signed on behalf of the patient by parent, legal guardian, personal representative, etc.

Please Note: You have the right to refuse to sign this form. We will not condition treatment on the completion of this authorization.