Atlas Mental Health

INFORMED CONSENT FOR TELEHEALTH SERVICES

I understand that telehealth is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when the individual is located at a different site than the provider; and hereby consent to Atlas Mental Health providing health care services to me via telehealth.

I understand that the laws that protect privacy and the confidentiality of medical information also apply to telehealth.

I understand that there are **risks and benefits** to telehealth as opposed to meeting in person for therapy.

I understand that some of the **advantages or benefits** of telehealth might include improved access to services, elimination of travel time to and from the office, greater comfort in attending from my home, and for some people, feeling more at ease within the therapeutic relationship. Telehealth can also be a great option when either the practitioner or client is sick and contagious as an alternative to canceling the session.

I understand that some of the **disadvantages or risks** of telehealth might include reduced privacy and confidentiality, the potential for weak internet connections or technology limitations interrupting or detracting from the flow and quality of sessions, reduced opportunity to read body language and non-verbal communication, and for some people, feeling less at ease within the therapeutic relationship.

I understand that current **research supports the benefits and effectiveness of telehealth for certain populations**. Depending on the study, this might include adults experiencing anxiety, depression, or post traumatic stress, children and adolescents in certain circumstances, rural residents, persons requiring added privacy compared to physically coming into a clinic, some persons experiencing chronic illness, and those with mobility impairments.

I understand that for other populations, the **research may not support the effectiveness or telehealth or in some cases there is simply limited research available**. These situations include persons experiencing severe mental illness, those who practically have limited access to technology and privacy such as persons experiencing homelessness, those in substance use treatment programs where supervised detoxification is required, people who have limited technology literacy or access, and non-English speakers where translation or interpretation services are not available. Many of these limitations can be mitigated but require specific attention and strategy to overcome.

I understand that **I or my practitioner may choose to discontinue using telehealth for services at any time**, especially if telehealth is determined to not be clinically appropriate for me.

I acknowledge that **I have had direct conversations with my practitioner about telehealth**, during which time I had the opportunity to ask questions and discuss any concerns. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in language I understand. I understand that my provider can answer any follow-up questions I may have.

I understand that **I may request that some or all of my services be in-person.** I further understand that since Atlas Mental Health is an online-only practice, **requesting in-person services will likely lead to**

a referral to a practice that can offer in-person services. This referral will be provided within two business days of the request.

I understand that practitioners with Atlas Mental Health are only able to practice in within the State of Oregon, and that **I must be physically located within the State of Oregon during all telehealth sessions**.

I understand that Atlas Mental Health uses **Zoom for Healthcare** and telephone sessions for the provision of telehealth. I am aware that my practitioner has purchased special subscriptions with Business Associate Agreements (BAA). While not eliminating all risks, these special subscriptions include **enhanced privacy protections** to safeguard my Protected Health Information (PHI) in accordance with HIPAA requirements.

I understand that **I am responsible for ensuring that the location from which I join sessions is private and confidential** and I agree to let my practitioner know about any circumstances that compromise my privacy.

I understand that if I am joining session from a **public place and/or operating a motor vehicle** during session, this session may be **ended immediately**. I further understand that if I am privately paying for services, I may be liable for cancellation fees in this event.

I agree to **refrain from bringing my electronic device into the bathroom** with me if I need to use the bathroom during my meeting.
I further attest that since I have chosen this form of communication, **I have been advised that it may not be covered by my insurance company** and that if I have private insurance (not Medicaid/Medicare/OHP) I am responsible for any fees incurred during psychotherapy which incorporates telecommunication.

I understand that **my therapist needs my accurate address on file for emergencies**, and I agree to provide this information. I understand that I may be asked to **verify my location** at the start of session.

I understand that **I may revoke this authorization at any time** by giving written notice, except to the extent Atlas Mental Health has already taken action in reliance on it. I may specify the date, event, or condition on which this consent expires. If none is stated, and if no prior notice of revocation is received, this consent will expire one year after the date it was initiated.

I understand that my practitioner is **committed to supporting my ongoing access to effective care** and that I am encouraged to reach out with any concerns or barriers that may arise during the course of work together.

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

Signature Date