Poehailos, Dupont & Associates, PLC

INFORMED CONSENT FOR MENTAL HEALTH TREATMENT BY VIDEO CONFERENCING

Poehailos, Dupont & Associates (PDA) is offering an interactive, real-time Video Conferencing (VC) platform (i.e. virtual “face-to face” sessions, also referred to by terms such as “telehealth”, “telemedicine”, “telebehavioral health”, or “telemental health”) in lieu of, or as a complement to in-office sessions. This modality can be used for all services offered aside from Psychological Testing. Video conferencing is a real-time interactive audio and visual technology that allows for the provision of mental health services remotely.

TECHNOLOGY
The VC platform currently in use at PDA is www.doxy.me. This platform meets HIPAA standards of encryption and privacy protection. Patients do not have to purchase a plan or provide your full name when engaging with this platform. The VC approach works best if you are connected to the internet. If you choose to rely on a data plan, the likelihood of session interruption is higher due to connectivity issues.

PHYSICAL LOCATION
Virginia licensure requirements allow for a clinician to conduct a VC session only in the state of licensure. You do not need to be at your home address to engage in a VC session, but you must be in the state of Virginia. At the beginning of each session, you may be asked to confirm the address where you are physically located and this may be noted in your clinical record.

INSURANCE COVERAGE
Your initials below indicate that you authorize me to submit claims to your insurance company for coverage of VC psychotherapy sessions.

INITIALS: ____________________________

If you choose to use your insurance to pay for VC sessions, the patient or guarantor will still be responsible for the copay/co-insurance/deductible. We recommend you put a credit card on file with the office, which can be done by completing the Registration Form or the Payment Form. As with any insurance billing, if there are issues with insurance reimbursement of VC sessions, we will alert you as soon as we become aware. We will then discuss how to proceed with sessions. If you have questions or concerns about your policy or coverage, you are strongly encouraged to contact your insurance company and/or the source of your policy, such as the human resources department at the guarantor’s place of employment.

POSSIBLE RISKS
Risks associated with VC may include (but are not limited to): the technology dropping due to internet or delays due to poor connections or other technology limitations; or a breach of information that is not under our control. For additional protection, you may want to clear your browser history and cache after engaging in VC sessions. Clinical risks may be discussed in more detail with your clinician but may include discomfort with virtual face to face treatment; difficulties interpreting non-verbal communication; and importantly, limited access to immediate resources if risk of self-harm or harm to others becomes apparent. We will discuss other specifics or concerns about VC with you before using the technology.

PRIVACY AND CONFIDENTIALITY

The laws that protect privacy and confidentiality of medical information also apply to telemedicine. Please ask me if you would like to review a copy of your HIPAA rights. It is recommended that you consider who may be in vicinity who could hear or see you engage in a VC session, and that you take steps to ensure your own privacy, including use of earphones and shielding your screen from view.

PHYSICAL ADDRESS from which you plan to engage in most VC appointments:

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INFORMED CONSENT

By signing this form, I certify that I have read this form, or had it explained to me;
that I fully understand the risks and benefits of receiving mental health services via VC;
that I have been given ample opportunity to ask questions and that my questions have been answered to my satisfaction;
that I understand I can withdraw my consent to the use of VC for psychotherapy at any time and this will not affect my future care.

NAME OF PATIENT: ________________________ DATE OF BIRTH: _________

LEGAL GUARDIAN (if minor patient): ____

SIGNATURE: ______________________ DATE SIGNED: ______________

Witness: ____

PDA Staff Initials: _______