SOLSTICE
MENTAL HEALTH TREATMENT

Telehealth Informed Consent

Thank you for scheduling with your practitioner at Solstice Mental Health Treatment (herein referred to as SMHT). Please read through the following important information.

TECHNOLOGY USED AND CONDITIONS OF APPOINTMENT

Telehealth involves the use of electronic communications to enable mental health care providers at SMHT to share individual patient medical or mental health information for the purpose of providing patient care. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records.
- Medical images.
- Live two-way audio and video.
- Sound and video files.
- Text and email communication.

Electronic systems and platforms used may include Zoom meetings, Google Duo, FaceTime, or Skype to provide ease of use and accessibility to the patient. These electronic forms of communication are not guaranteed to be encrypted for the purposes of confidentiality and are not HIPPA compliant. Signing this document acknowledges that participating in telehealth with SMHT practitioners via these platforms has security risks.

Prior to your appointment, you will be able to communicate with your practitioner about which platform you prefer to use and which one is most accessible to you. Your practitioner will contact you using this agreed upon platform at the time of your scheduled appointment. You do not need to initiate the appointment. Your practitioner will send you a reminder of this appointment the day before it is scheduled to confirm the contact method and time. Your appointment will take place in a virtual 'meeting.'

Your practitioner will need to be able to hear you clearly. Please plan to have your telehealth session in a quiet place without background noise and other distractions. Be mindful of people in your surroundings to protect your own privacy. Please ensure that if you cannot hear properly on your end of the call or need instructions repeated that you inform your provider. For patient privacy, telehealth sessions may not be recorded by either the patient or the practitioner.

Your practitioner will need to confirm that it is indeed you. You will need to have sufficient lighting so that your physician can see you clearly. Please identify any persons who are outside the field of view but are participating in or listening to the call. To ensure the privacy of your information, please make sure you are in a safe and private location. *

I agree to the above statement(s).

POSSIBLE RISK:

· In very rare instances, security protocols could fail, causing a breach of privacy of personal information. *

I agree to the above statement(s).

BY SIGNING THIS FORM, I UNDERSTAND THE FOLLOWING:

1. I understand that the laws that protect privacy and the confidentiality of health information also apply to telemedicine, and that no information obtained in the use of telehealth which identifies me will be disclosed to researchers or other entities without my consent, and outside of those uses permitted by law.

2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time.

3. I understand that a variety of alternative methods of treatment may be available to me through alternative providers, and that I may choose one or more of these at any time.

4. I understand that telehealth may involve electronic communication of my personal information via electronic technology, and that there may be risks associated with transmitting information electronically including theft, hacking, or data compromise.

5. I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.

6. I understand that communication may be lost during our visit due to technical failures, and that every effort will be made to preserve call quality and to resume an encounter if it is prematurely disconnected.

SOLSTICE
MENTAL HEALTH TREATMENT

7. I understand that telehealth visits should NOT be scheduled with SMHT or its providers for emergency situations, and that it is my responsibility to seek emergency care immediately if I am having an emergency.

8. SMHT providers will assess patients individually to determine if they are appropriate telehealth candidates based on symptoms, diagnosis, stability, and severity of conditions and have the right to refer patients to appropriate alternative resources if necessary based on provider evaluation, observation, and assessment when telehealth is not deemed to be safe or appropriate.

9. I have read, understood, and agree to all items contained in this document.

10. I voluntarily consent to telehealth care for myself or my dependent.

_____ _____

PATIENT OR GUARDIAN SIGNATURE * DATE