PATHWAYS
Mental Health Services

4804 – A & B, Lacey Blvd. SE Lacey, WA 98503
Phone: 360-799-5782 ~ Fax 360-539-1715

831 12th Avenue Longview, WA 98632
Phone: 360-799-4556 ~ Fax : 360-846-1722

TELEMEDICINE/TELEHEALTH INFORMED CONSENT

I _____ [name of patient] hereby consent to engaging in telemedicine at Pathways Mental Health Services, LLC as part of my psychotherapy. I understand that "telemedicine" includes the practice of health care delivery, assessment, diagnosis, consultation, treatment, transfer of medical data, and psychoeducation using interactive audio, video, or data communications. I understand that, with my signed consent, telemedicine may also involve the communication of my mental health information, both orally and visually, to other health care practitioners located in Washington State.

Technology: I understand that I will need to download an application and/or software to use this platform. I also need to have a broadband Internet connection or a smart phone device with a good cellular connection at home or at the location deemed appropriate for services. I also understand that in case of technology failure, I may contact Pathways Mental Health Services, LLC via phone to coordinate alternative methods of treatment.

Financial Obligations: Fees associated with telemedicine appointments are payable by credit or debit card only. If fees may be associated with my telemedicine services, I agree to have my credit/debit card information on file with Pathways. My card will be billed the same day as my scheduled telemedicine appointment. If my card is declined, Pathways will cancel my appointment and I will be charged in accordance with the cancelation policy. (Client Initial: _____)

Clients using insurance: I am responsible for contacting my insurance company, if applicable, to determine what my out-of-pockets costs may be. I authorize insurance benefits to be paid directly to Pathways Mental Health Services and that Pathways may release any information to my insurance provider required for processing my claims. (Client Initial: _____)

Self-Pay clients: I am aware of the fees associated with telemedicine appointments and agree to pay at the time of my appointment. I understand that I am responsible for cancelled telemedicine appointments in accordance with the Pathways MHS cancellation policy as documented by my signature on the Informed Consent. (Client Initial: _____)

I understand that using the Telemedicine platform allows access to mental health services that might not otherwise be available to me due to my mental health, and/or my physical, resource, or geographic limitations.

Scheduling: I understand that scheduling is conducted through Pathways and is based on my provider's normal clinic hours. Telemedicine appointments are considered outpatient services and not intended as a substitute for emergency or crisis services. Crisis or mental health emergencies should be directed to the local county crisis line or by dialing 911.

Video/Audio Recording: As a general practice Pathways MHS DOES NOT record Telemedicine sessions without prior permission.

Confidentiality: The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality including, but not limited to: reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. Pathways' Telemedicine platform is HIPAA compliant to protect my privacy and confidentiality. This is further explained in the Mental Health Informed Consent, which I have signed.

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I understand that I have the following rights with respect to telemedicine:

1. I have the right to withdraw my consent at any time.
2. I understand that there are risks and consequences associated with telemedicine including, but not limited to the possibility, despite reasonable efforts on the part of my counselor/therapist/clinical intern, that the transmission of my medical information could be disrupted or distorted by technical failures. In addition, I understand that telemedicine-based services and care may not be as complete as face-to-face services. I also understand that if my counselor/therapist/clinical intern believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services) I will be referred to a counselor/therapist who can provide such services in my geographic area.
3. I understand that I may benefit from telemedicine but that results cannot be guaranteed or assured.
4. I understand that I have a right to access my mental health information and copies of medical records in accordance with Washington state law.

I have read and understand the information provided above. I have discussed it with my counselor/therapist/clinical intern, and all of my questions have been answered to my satisfaction. My signature below indicates my informed and willful consent to treatment using this platform.

_____ _____
Client Signature Date

_____ _____
Client Guardian's Signature Date

_____ _____
Provider's Name & Signature Date