Olive Tree Counseling, Inc.
5730 E. Pilgrim Court, Suite A, Wasilla, Ak 99654
907-357-6513

PATIENT CONSENT TO ELECTRONIC COMMUNICATIONS

Olive Tree Counseling Employees will not routinely use electronic communication with clients. Any use of electronic communication with clients must be pre-approved by owners of OTC and the reasons for this choice will be documented in the client records.

Communication Consent

If you personally wish for Olive Tree Counseling, Inc to review your need to communicate via Email and/or Fax, please indicate the necessity and provide a valid email address and/or fax number.

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Please initial the appropriate lines below.

_____ I do **NOT** need to communicate with Olive Tree Counseling via E-mail or Fax

_____ I do wish to communicate via email. Email address:____

_____ I do wish to communicate via fax. Fax number: ____

I have received, read and understand the Email and Other Electronic Communications Policy and have initialed my communication preferences above. If I have authorized email communications, I do so with the following understanding:

E-MAIL CAN BE MISDIRECTED TO OR INTERCEPTED AND DISCLOSED BY UNINTENDED THIRD PARTIES AND THUS MAY NOT A CONFIDENTIAL MEDIUM OF COMMUNICATION. PATIENTS WHO HAVE CONCERNS SHOULD CONSIDER USING ANOTHER MODE OF COMMUNICATION. PATIENTS UNDERSTAND AND AGREE THAT E-MAIL TRANSMISSION IS BEING USED FOR THE CONVENIENCE OF PATIENTS AND OLIVE TREE DOES NOT WARRANT THE CONFIDENTIALITY AND SECURITY OF THIS TRANSMISSION. PATIENTS, AND IN PARTICULAR, THOSE PATIENTS WHO HAVE MULTI-USER E-MAIL ACCOUNTS, ARE RESPONSIBLE FOR MAINTAINING THE CONFIDENTIALITY AND SECURITY OF THEIR OWN E-MAIL ACCOUNTS.

Telehealth Consent

Using telehealth services is entirely voluntary and will not impact the quality of care you receive from Olive Tree Counseling, Inc should you decide not to use these services. This office will not condition treatment or payment for health care on whether or not you use telehealth services or sign this agreement.

Olive Tree Counseling Inc is not liable for any claims and/or damages arising from the use of telehealth services.

_____ I do wish to use telehealth services. Email address:____

_____ I do not need to use telehealth services.

By signing below, you acknowledge that you have read and fully understand the Olive Tree Counseling, Inc Electronic Communications Policy. You have been given the risks and benefits of such services and technologies, and understand the risks associated with online communications with Olive Tree Counseling, Inc and consent to the conditions as indicated herein. In addition, you agree to adhere to the policies set forth above, as well as any other instructions or guidelines that Olive Tree Counseling may impose for using the electronic communications.

____

Print Name Patient Signature Date

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Print Name of Parent/Guardian Signature Date

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Consent for Telehealth/Telemedicine

Alaska Telehealth/Telemedicine Definition
Alaska policy and regulations telemedicine references
Senate Bill 74

Defines telehealth/telemedicine as the practice of health care delivery, evaluation, diagnosis, consultation, or treatment using the transfer of health care data through audio, visual, or data communications, performed over two or more locations between providers who are physically separated from the recipient or from each other or between a provider and a recipient who are physically separated from each other.

As a client receiving behavioral health services through technologies, I understand:

1. The interactive technologies used in tele-behavioral health incorporate network and software security protocols to protect the confidentiality of client information transmitted via any electronic channel. These protocols include measures to safeguard the data and to said in protecting against intentional or unintentional corruption.
2. This service is provided by technology and may not involve direct face to face communication. There are benefits and limitations to this service.
    a. Electronic systems used will incorporate network and software security protocols to protect the privacy and security of health information and imaging data and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption. These services rely on technology, which allows for greater convenience.
    b. There are risks in transmitting information over technology that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties.
    c. In emergencies, disruption of services, or for routine or administrative reasons, it may be necessary to communicate by other means: i.e. through the cell phone number provided by your provider.
    d. In the event of disruption of services, I will attempt to re-establish service at least twice before attempts to communicate via cell phone.
3. I will need access to, and familiarity with, the appropriate technology in order to participate in the service provided.
4. The exchange of information will not be direct, and any paperwork exchanged will likely be provided through electronic means or through postal delivery.
5. During my tele-behavioral health consultation, details of my medical history and personal health information may be discussed with myself or other behavioral health care professionals through the use of interactive video, audio, or another telecommunications technology.
6. If a need for direct, in-person services arises, it is my responsibility to contact my practitioner, or practitioners in my area such as another provider in my behavioral practitioner's office or obtain an appointment with my primary care physician if my behavioral practitioner is unavailable. I understand that an opening my not be immediately available in other offices.
7. My practitioner and I will regularly reassess the appropriateness of continuing to deliver services to me through the use of the technologies we have agreed upon today and modify our plan as needed.

Consent for Telehealth

8. It is my responsibility to maintain privacy on the client end of communication. Insurance companies, those authorized by the client, and those permitted by law may also have access to records or communications
9. I will take the following precautions to ensure that my communications are directed only to my behavioral health provider or other designated individuals:

    a. ____

    b. ____

10. I may decline any tele-behavioral health services at any time without jeopardizing my access to future care, services, and benefits.
11. Records of my communication/sessions will be stored in the same manner that face to face records are stored.
12. The laws and professional standards that apply to in-person behavioral services also apply to telehealth services. This document does not replace other agreements, contracts, or documentation of informed consent.

I have read this document carefully, and my questions have been answered to my satisfaction.
My signature below shows that I understand and agree with all these statements.

_________________________________ _________________________________ ____________

Printed name of Client Signature or client Date

_________________________________ _________________________________ ____________

Printed name of Parent/Guardian Signature Date

___Shelly J. Thomas, LMFT ___Rae Ann Hendrickson, LPC ___Brittney Punt, LCSW ___Derek Sandlin, LPC

___________________________________ ______________

Signature of therapist Date