Video-Conferencing/TeleHealth/TelePsychology AUTHORIZATION

CLIENT NAME:_____

DATE OF BIRTH:_____ CLIENT #:_____

Dr. Kim Tousignant: **Mailing Address:PO Box 1694; Physical Address:151 Main St., Suite 2; BUCKSPORT, ME 04416**
Phone #: 207/944-8881 FAX: 207/469-1932 FB: drkimtousignant Website: www.shocksnomore.org

Doxy.me is my chosen Video-Conferencing site. Internet address to type in: **https://doxy.me/drkimt**
You DO NOT NEED a free-standing application for this new Videoconferencing site. It works with FireFox or Chrome. On your Android phone use Google Chrome.
Here is a You Tube Video showing how to use it. **https://youtu.be/yJf9N9sjDLI**

Dr. Kim Tousignant is offering Video-Conferencing services to active clients who reside in the State of Maine, where I am licensed as a Psychologist. There may be potential benefits and risks of Video-Conferencing (e.g. limits to patient confidentiality) that differ from in-person sessions. The following guidelines and limitations are designed to increase client safety on both ends of the conferencing.

DR. KIM'S RESPONSIBILITIES:

- Your confidentiality remains one of Dr. Kim's utmost concerns.
- Doxy.me is a Video-conferencing site designed for health professionals that has state-of-the-art-encryption that meets HIPAA requirements. Even so, **anything based on the internet** has the potential to not be a secure form of information transmission, as there may be risks Dr. Kim cannot control.
- Dr. Kim will provide assistance in the use of this application to the best of her ability.
- Dr. Kim agrees to use only personal Wi-Fi and will not use public Wi-Fi sites. She will use a computer or smartphone.
- Dr. Kim agrees to have a quiet, confidential space to conduct TelePsychology, preventing any other person to be within an area to hear our session. Should any concern arise Dr. Kim or the client will have the right to exclude anyone from either site.
- Your status as an open client to Dr. Kim will never be predicated upon use, or lack of use, of Telehealth services.
- As with in-office sessions, no session will be recorded by Dr. Kim without your express signed authorization.
- Dr. Kim will continue to document sessions and retain records, via the usual means, as required by State and Federal laws, in writing. In addition, Dr. Kim is required to notate that services were conducted via TeleHealth, the location of the provider and the location of the client, and any interferences that occur.
- If clients do not have the capabilities required for Telehealth but desire Video-Conferencing, Dr. Kim agrees to assist clients in accessing nearby locations with video-conferencing services.
- Dr. Kim agrees to continually assess whether the Video-Conferencing method of providing services continues to meet a client's needs for psychotherapy services. She may, at any time, determine, due to circumstances, in-person sessions will be required. Dr. Kim agrees to discuss these issues as they arise, and when possible consult with client during decision-making.
- Dr. Kim agrees to develop a back-up-plan, with the client, in the event of technical difficulties or crisis situations. This may include: an active phone number to restart or finish the session; An emergency contact and clarification of the closest Emergency Room; access to Crisis Services, etc.
- If a client is under age 18 Dr. Kim agrees to have Parent(s) written permission for Video-Conferencing to occur, as laws require.
- Dr. Kim must obtain your physical location and an alternative emergency phone number in case of emergency (say you have a medical emergency) at the beginning of every session.

CLIENT RIGHTS:

I, _____(name) understand I have the right to:

- Request limitations, accommodations, even stop any session that has begun, if I so desire. I can also refuse services via Telehealth, requesting they be in-office only. However, there may be limitations to Dr. Kim's ability to provide timely service based upon Town, State and Federal guidelines, i.e. if Dr. Kim or I become quarantined due to health concerns, etc.
- Obtain a copy of this authorization, and to review and copy any information.
- Review my records, as is afforded in my usual State and Federal Rights.
- MaineCare clients have the right to get transportation (per MaineCare guidelines) to a facility where they can access Telehealth, if they desire.
- Revoke this authorization by written notice to the health care provider at any time, except where the health care provider has already acted upon the authorization. (See exception to this Right in the Notice of Privacy Practices in the client materials and links given to you at intake).

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CLIENT RESPONSIBILITIES: I, _____(name), agree to review these carefully.

- A scheduled TeleHealth Appointment **shall be considered the same as an in-person session in regards to scheduling. It is important to be available at the scheduled time**. I agree to notify Dr. Kim in ADVANCE, by phone, email, text or other messaging program we have agreed to use, should you need to cancel an appointment. There may be cancellation and/or No Show fees, as allowed by your insurance.
- I understand that participation in Telehealth services with Dr. Kim is completely voluntary.
- To access TelePsychology from home I will need to use a computer with webcam, laptop with webcam, or smart phone. Alternatively, I may be able to travel a short distance to a designated location.
- I agree to have a quiet, confidential space where I can participate in the Video-Conferencing. I agree to disclose any other person that may be within an area to be able to hear our session. PLEASE NOTE: If you have a server such as Google Home, Google Nest, Alexa, Suri, Echo,etc. are constantly listening and some may be recording. It is recommended these be turned off if you think they can hear you in a room. Should any concern arise I understand either I or Dr. Kim have the right to exclude anyone from either site.
- I agree to confirm with my insurance company that they will reimburse for TeleHealth Services. If any pre-authorizations are needed I must alert Dr. Kim in ADVANCE. If they are not reimbursed, I am responsible for full payment as agreed in the authorization to bill document.
- Should I feel the desire to record sessions, Dr. Kim requires I let her know in advance so she can sign confirmation to that effect.
- I agree to discuss my opinions and concerns about the Video-Conferencing method if it is uncomfortable or interferes in my receipt of psychotherapy.
- I agree to work with Dr. Kim to develop a back-up-plan in the event of technical difficulties or crisis situations. This may include: an active phone number to restart or finish the session; An emergency contact and clarification of the closest Emergency Room; access to Crisis Services, etc.

This authorization for TELEHEALTH Services is to be **in effect through** _____(date) unless otherwise revoked.

As with all psychotherapeutic services, results may be helpful or cause unexpected outcomes and all possible outcomes are impossible to predict.
I agree to accept the risks and responsibilities noted above and voluntarily request and allow Dr. Kim to interact with myself utilizing TELEHEALTH services in order to serve my best interest:

_____ _____
Client Signature **Date**

_____ _____ _____
Signature of Authorized Person Basis for Authorization (Relationship to Client) Date

_____ _____
Witness Date

REVOCATION: I hereby revoke this Authorization for TELEHEALTH Services. I fully understand this does not apply to information that has already been released.

_____ _____
Client Signature Date

_____ _____ _____
Signature of Authorized Person Basis for Authorization (Relationship to Client) Date (**REVISED 3/17/2020**)