MURRAY, WILSON & ROSE
COUNSELING AND BEHAVIORAL SERVICES

Telehealth Informed Consent for Medication Management

This form is intended to allow you to give consent to be seen via telehealth for your medication management sessions. Read it thoroughly for understanding, and ensure that any questions have been answered before signing to give consent.

This is used in conjunction with, but does not replace, the informed consent that you are required to sign prior to being seen for medication management.

Telehealth sessions will take place via thera-LINK, a HIPAA compliant platform that uses video and audio technology via webcam to connect you with your provider securely. Thera-LINK uses encrypted data streams (AES-265) for video sessions. Any data that is stored outside of the video session on the thera-LINK (such as documents, messages, or progress notes) is encrypted and meets or exceeds all HIPAA and HITECH guidelines.

The benefits of telehealth sessions include the convenience of location, time, wait times, and accessibility which allows for better continuity of care. In addition, telehealth sessions allow for greater accessibility to services for patients with limited mobility of lack of transportation.

With all technology, there are some limitations. Technology may occasionally fail before or during sessions. The problems that are related to internet connectivity, difficulties with hardware, software, equipment, and/or services supplied by a third party. Any problems with internet availability or connectivity are outside the control of your provider, and your provider makes no guarantee that such services will be available or will work as expected. If something occurs to prevent or disrupt any scheduled appointment due to technical complications and the session cannot be completed via thera-LINK, your provider will either use the in-session video chat to troubleshoot or will call you back to complete the session. Please list your main phone number (and an alternate if available) here: _____

If, for any reason, you are unable to connect to the session and you are in an immediate crisis or a potentially life threatening situation, please get immediate emergency assistance by calling 911 or visiting your nearest emergency room.

I agree to take full responsibility for the security of any communications or treatment on my own computer, phone, or tablet and in my own physical location. I understand I am solely responsible for maintaining the strict confidentiality of my user ID and password and will not allow another person to use my ID to access services. I also understand that I am responsible for using this technology in a private and secure location so that others cannot hear my conversation.

I understand that there will be no recording of the online session and that all information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without my written permission, except where disclosure is required by law.

I understand that I am not allowed to do any recording, screenshots, etc. of any kind, of any session, and to do so is grounds for termination of the patient-provider relationship.

Consent to Treatment

I, _____, voluntarily agree to receive online services for an assessment, continued care, treatment, or other services and authorize Murray, Wilson & Rose Counseling and Behavioral Services, LLC. to provide such care, treatment, and/or services as are considered necessary and advisable. I understand and agree that I will participate in the planning of my care, treatment, and/or services and that I may withdraw consent for such care, treatment, and/or services that I receive through Murray, Wilson & Rose Counseling and Behavioral Services, LLC. at any time. I understand that I will work with my provider from Murray, Wilson & Rose Counseling and Behavioral Services, LLC.; and together we will determine on an on-going basis whether the condition being assessed and/or treated is appropriate for online sessions.

I understand that it is my responsibility to verify covered benefits if I am using health insurance, and I agree to be responsible for any unpaid charges for my sessions after claims have been submitted on my behalf.

By signing this informed consent, I, the undersigned patient, acknowledge that I have both read and understood all the terms and information contained herein. I have had the opportunity to ask questions and seek clarification about any information that is unclear to me.

Patient name: _____ Date: _____

Patient signature: _____