West County Psychological Associates

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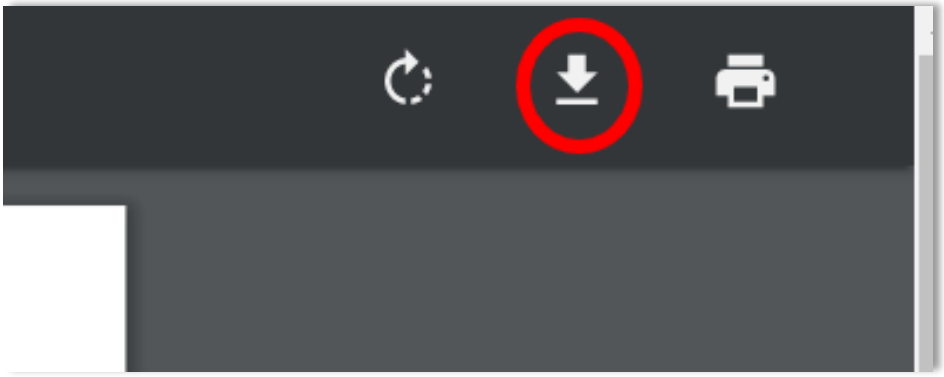
Instructions

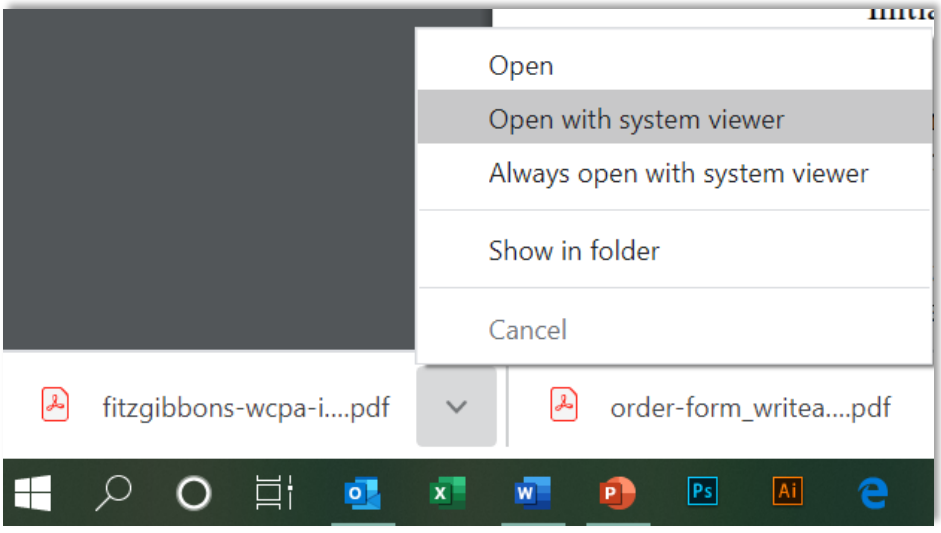
Download the Form

You must view this form in Acrobat to successfully save your data. Please download this document as shown below (upper right-hand corner)

Then complete the form and save to your computer. For security purposes, completed forms must be uploaded to www.wcpastl.com/upload. Please do not send forms to any of our email addresses. Forms must be received 48 hours prior to your scheduled appointment.



Open with System Viewer as shown below.



West County Psychological Associates

Informed Consent for
Telehealth Testing Services

I _____ (name of adult client or child's legal guardian) hereby consent to engage in telehealth psychological testing services for myself/my child through West County Psychological Associates (WCPA). I understand that telehealth testing services may include consultation, interview, assessment, testing, diagnosis, transfer of medical data, telephone conversations, feedback, and/or education using interactive audio, video, or data communications. I understand that telehealth testing services also involves the communication of my medical/mental health information, or that of my child, verbally and/or visually.

I understand that I have the following rights with respect to telehealth testing services:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future testing, care or treatment.

2. The laws that protect the confidentiality of my medical information also apply to telehealth services. As such, I understand that the information disclosed by me during the course of telehealth testing services is generally confidential. However, there are limits and exceptions to confidentiality with telehealth services, just as there are with in-person testing services. These include, but are not limited to, reporting child, elder, and dependent adult abuse and expressed threats of harm.

3. I understand that there are risks and consequences from telehealth testing services, including, but not limited to, the possibility, despite reasonable efforts on the part of WCPA that: the transmission of my information could be disrupted or distorted by technical failures, the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

4. In addition, I understand that telehealth based services and care may not be as complete as face-to-face services. My clinician cannot see me, my body language, or my non-verbal reactions to what we are discussing as clearly as may be seen in person. My clinician may not hear all of what I am saying and may need to ask me to repeat and clarify more often than during face-to-face discussions. Confidentiality is not as assured as it may be during face-to-face services.

5. I understand that I may benefit from telehealth testing services, but that results cannot be guaranteed.

6. I accept that telehealth services through WCPA does not provide emergency services. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help, or call my primary care physician or psychiatrist. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) or text 741741 for free, 24 hour hotline support.

7. I understand that I am responsible for providing the necessary telephone or internet-connected devices and internet access for my telehealth testing services and arranging a location with sufficient privacy that is free from distractions or intrusions.

8. I understand the same fee rates will apply for telehealth testing services as apply for in-person services. Although WCPA does not submit invoices for insurance payment, some testing clients may choose to submit these invoices for reimbursement after paying for WCPA services. However, insurance or other managed care providers may not cover sessions that are conducted via telecommunication. If I wish reimbursement, it is my responsibility to contact my insurance company prior to engaging in telehealth testing services in order to determine whether these services will be covered.

9. I agree that the telehealth testing services shall not be recorded in any way unless agreed to in writing by mutual consent. My clinician will maintain a record of our services in the same way (s)he maintains records of in-person services.

10. I understand that telehealth services through WCPA will only be conducted through telephone and/or online video services. Professional services will not be provided through email or text. Email and text communications with my clinician may only be used for setting or adjusting appointments.

11. I understand that I have additional rights and responsibilities, which are outlined in the document *West County Psychological Associates Informed Consent for Testing Services*, which I have also been provided.

By signing below, I acknowledge that I have both read and understood the information in this document and in *West County Psychological Associates Informed Consent for Testing Services*, and agree to the terms of both documents. This consent ends when I notify my clinician that I am terminating telehealth testing services or one year following my receipt of the written report describing my testing results.

Adult Clients:

Name of Adult Client: _____

Signature of Adult Client:

_____ Date: _____

Minor Clients:

In the case of a minor client, the signature of a parent is required. <u>NOTE:</u> If parents are divorced or legally separated, the signatures of both parents are required unless otherwise stated in the legal parenting plan.

Name and Age of Minor Client: _____

Signature: _____ Date: _____

Signature: _____ Date: _____