

Telehealth Policies and Procedures

Bethesda Christian Counseling will offer telehealth services as a form of providing therapy services only during times when deemed necessary due to circumstances in the world. Telehealth has been proved to be as effective as face to face counseling and is an effective way to receive counseling services to help manage mental health symptoms, treat mental health illness and improve overall mental health when a patient is unable to present to our office. Please note that we are only offering telehealth services to deal with these temporary extenuating circumstances currently limiting us from offering in person therapy sessions.

Bethesda Christian Counseling will use a HIPPA compliant, audio and video, two-way interactive website. The client and our therapist will each use their own audio/visual telecommunications technology (i.e. computer, smartphone). This type of service is also referred to as “real-time” and may serve as a substitute for an in-person session. You will need to provide your own computer with webcam capabilities, have access to email and know some minor basics about using email. You will be required to have your own email address, not a shared email.

Confidentiality is very important for all of us here at Bethesda Christian Counseling and we will follow all state and federal guidelines.

You must be willing to comply with standards and practices of safe telehealth services which include but are not limited to some of the following criteria:

Privacy Measures for the Client—Expectations of the client:

- Avoid using mind altering substance prior to the session
- Dress Appropriately
- Hold the session in an appropriate room (not a bedroom) when attending a web-based session
- Do not have anyone else in the room unless you first discuss it with your counselor
- Do not conduct other activities while in session, such as driving
- Do not record sessions
- Be located within the State in which the clinician is licensed to practice (client should inform the clinician of their location)
- With the use of technology, it is important to be aware that family, friends, co-workers, employers or hackers may have access to any technology, devices or applications that you use.
- Do not keep your therapist’s contact information on your phone if it is synced with other accounts/applications
- Notify your therapist if you suspect any breach in your security.

Emergency Management for Telehealth

So that we can get you help in case of emergency and for your safety the following are important and necessary. In addition, by signing this agreement form you are acknowledging that you understand and agree to the following:

- You, the client, will inform me, your therapist, of the location in which you will consistently be during our sessions and will inform me if this location changes.
- You, the client, will identify, on this client information form, a person, whom I, your therapists, can contact in the case that I believe you are a risk of harming yourself or others.

- Depending on my assessment of risk, you, the client, or I, your therapist, may be required to verify that your emergency contact person is able and willing to go to your location in the event of an emergency, and if I deem necessary, call 911 and/or transport you to a hospital. In addition, I may assess, and therefore require, that you create safe environment at your location during the entire time that you are in treatment with me. This may mean disposing of all firearms and excess medications from your location.

Cost & Payment

In most cases telehealth is covered by insurance, please remember, however, **that any services you receive at Bethesda Christian Counseling that are not covered by insurance are ultimately your responsibility to pay.** It is your responsibility and we highly recommend that you contact your insurance company to find out if they cover telehealth services prior to any appointment. You may pay privately for telehealth services. The same rates that apply for face to face therapy apply to telehealth services. It will be your responsibility to pay your co-pay, co-insurance, deductible or non-covered charge the day of the service. You may make a credit card payment over the phone or send a check into our Sioux Falls office. We reserve the right to cancel future appointments should you continually fail to pay or make appropriate arrangements to pay the amount owed.

Safety and Patient-Provider Relationships

Patients should trust that providers will offer necessary information for patients to make decisions about treatment. They should also expect competent care, assurance of privacy and confidentiality and continuity of care. Providers' ethical responsibilities remain the same with telehealth, but differences in possible patient-provider interactions in telehealth have brought accountability and the patient-provider relationship to the forefront in discussions about telehealth safety. As an avenue for service delivery, telehealth will only be used by Bethesda Christian Counseling during a time of extenuating circumstances as set forth by the clinical director and board. It will not be offered as a substitute for face to face counseling at any other time.

If you are interested in utilizing the telehealth services at this time you must read and sign this document. You must also read and sign the Informed Consent to Telehealth. Once you have signed both documents you will need to get those back to our office. You may scan and email them to info@bethesdachristiancounseling.org, fax them to 605-334-7752 or mail them to our Sioux Falls office (address is at the bottom of the first page).

Client Signature

Print Client Name

Date

Risk Contact Person Name

Risk Contact Person Phone Number

Staff Signature



Informed Consent for Telehealth

Telehealth allows my therapist to diagnose, consult, treat and educate using interactive audio, video and/or data communications regarding my treatment. I hereby consent to participating in psychotherapy via the internet (hereinafter referred to as Telehealth) with the clinician listed below:

Client Name: _____

Clinician/Therapist: _____

I understand I have the following rights under this agreement:

1. I have a right to confidentiality with Telehealth under the same laws that protect the confidentiality of my medical information for in-person psychotherapy. Any information disclosed by me during the course of my therapy, therefore, is generally confidential. There are, by law, exceptions to confidentiality, including mandatory reporting of child, elder and dependent adult abuse and any threats of violence I may make towards a reasonably identifiable person.
2. I also understand that if I am in such mental or emotional condition to be a danger to myself or others, my therapist has the right to break confidentiality to prevent the threatened danger.
3. I understand that the circulation of any personally identifiable images, or information from the Telehealth interaction, to any other entities shall not occur without my written consent.
4. I understand that while psychotherapeutic treatment of all kinds has been found to be effective in treating a wide range of mental disorders, personal and relational issues, there is no guarantee that all treatment of all clients will be effective. Thus, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.
5. I understand that there are risks unique and specific to Telehealth, including but not limited to the possibility that our therapy sessions could be disrupted or distorted by technical failures or could be interrupted or accessed by unauthorized persons.
6. I understand that I am responsible to provide the communication device, it's software, functionality, the security on the device and my ability to use the audio/visual platform. Since these are my responsibility, I understand that it is my responsibility to uphold confidentiality measures on my end related to my device and environment and will not hold the therapist accountable for any inadvertent disclosures that may occur.
7. I understand that any fees not covered by my insurance company are my responsibility to pay.

I have read and understand the information provided above. I have the right to discuss any of this information with my therapist and to have any questions I may have regarding my treatment answered to my satisfaction. I understand that I can withdraw my consent to Telehealth communications by providing written notification to Bethesda Christian Counseling at the address below. My signature below indicates that I have read this Agreement and agree to its terms.

Signature of Client/Personal Representative

Client DOB

Date

Printed Name of Client/Personal Representative

Relationship to Client

Email you would like us to use to send the telehealth link

Signature of Staff Member

Printed Name of Staff Member

Date