# Vista Psychological & Counseling Centre, LLC

4845 Fulton Rd. NW | Suite 4 | Canton, Ohio 44718
Phone: 330.244.8782 | Fax: 330.244.8795
www.vistapcc.com


Patient Name: _____ DOB: _____

Email Address: _____ Phone: _____

I, the undersigned, a citizen of Ohio, in the U.S.A., or my designee(s), on my behalf, agree to participate in phone/video-conference counseling with _____, a mental health care provider. This means that I authorize information related to my medical and mental health care to be electronically transmitted in the form of voice, images and data through an interactive telephonic/video connection to and from the above named provider, other persons involved in my health care, and staff operating the phone/video-conferencing equipment.

I represent that I am using my own equipment to communicate and not equipment owned by another, specifically not using my employer's computer or network.

I understand that I will be informed of the identities of all parties present during the phone/video-conference counseling and of their purpose for attending. I understand that I will also be required to inform my provider of all parties present during the phone /video-conference counseling and of their purpose for attending.

My provider has explained how tele-behavioral health phone/video-conference counseling is performed and how it will be used for my treatment. My provider has also explained how the phone/video-conference counseling will differ from in-person services, including but not limited to emotional reactions that may be generated by the technology.

In brief, I understand that my provider will not be physically in my presence. Instead, we will see and hear each other electronically. Some information my provider would ordinarily get in face-to-face counseling my not be available in phone/video-conferenced counseling. I understand that such missing information could in some situations make it more difficult for my provider to understand my problems and help me get better. My provider will be unable to touch me or to render any emergency assistance.

I understand that phone/video-conferenced counseling is a new form of treatment, in an area not yet fully validated by research, and that it has potential risks, possibly including some that are not yet recognized. Among the risks that are presently recognized are the possibility that the technology will fail before or during the phone/video-conference counseling, that the transmitted information in any form will be unclear or inadequate for proper use in the phone/video-conference counseling, and that the information will be intercepted by an unauthorized person or persons.

I authorize the release of any information pertaining to me determined by my provider, my health care providers or by my insurance carrier to be relevant to the phone/video-conferenced counseling or processing of insurance claims, including but not limited to my name, Social Security number, birth date and clinical or medical record information.

I understand that at any time, the phone/video-conferenced counseling can be discontinued either by me or by my designee(s) or by my provider. I further understand that I do not have to answer any question that I feel is inappropriate or whose answer I do not wish persons present to hear, that any refusal to participate in the phone/video-conferenced counseling will not affect my continued treatment, and that no action will be taken against me. I acknowledge, however, that diagnosis depend on information, and treatment depend on diagnosis, so if I withhold information, I assume that risk that a diagnosis might not be made or might be made incorrectly. Were that to happen, my treatment might be less successful than it otherwise would be, or it could fail entirely.

I also understand that, under law, and regardless of what form of communication I use in working with my provider, my provider may be required to report to authorities any information suggesting that I have engaged in or intend to engage in behavior that endangers myself and/or others.

The alternatives to phone/video-conference counseling have been explained to me, including their risks and benefits, as well as the risks and benefits of doing without treatment. I understand that I can still pursue in-person counseling. I understand that the phone/video-conference counseling does not necessarily eliminate my need to see a specialist in person, and I have received no guarantees as to the phone/video-conference counseling's effectiveness.

I understand that my phone/video-conferenced counseling sessions will not be recorded by my counselor nor will they be recorded by me or my designee(s). I understand that counseling, test results, and disclosures will be held in confidence subject to state and/or federal law. I understand that I am ordinarily guaranteed access to my medical records and that copies of records are available to me on my written request. I also understand, however, that if my provider, in the exercise of professional judgement, concludes that providing my records to me could threaten the safety of a human being, myself or another person, he or she may rightfully decline to provide them. If such a request is made and honored, I understand that I retain sole responsibility for the confidentiality of the records released to me and that I will have to pay a reasonable fee to get a copy. Additionally, I understand that my records may be used for tele-behavioral health program evaluation, education, and research and that I will not be personally identified if such a use occurs. I hereby authorize these disclosures to take place without prior written consent.

I understand that I am not entitled to royalties or to other forms of compensation for participation in tele-behavioral health video conferencing.

I have received a copy of my provider's contact information, including his or her name, telephone number, pager and/or voice mail number, business address, mailing address, and email address.

I have also been provided with an action plan in case of emergency. I acknowledge however, that if I am facing or if I think I may be facing an emergency situation that could result in harm to me or to another person, I am not to seek tele-behavioral health video conferencing. Instead, I will seek care immediately through my local health care provider or the nearest hospital emergency department or by calling 911.

These are names and telephone numbers of local emergency contacts (including local physician; crisis hotline; trusted family, friend, or advisor) that I have identified and recorded along with my provider. I will reference and contact them in the event of an emergency, since my provider will not be physically available to me.

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| Vista Psychological & Counseling Centre | 330.244.8782 |
| Crisis Center of Stark County | 330.452.6000/800.956.6630 |

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

I unconditionally release and discharge Vista Psychological & Counseling Centre, LLC, its affiliates, agents, employees, and my provider and his or her designee from any liability in connection with my participation in the remote tele-behavioral health video-conference counseling.

I have read this document carefully and fully understand the benefits and risks. I have had the opportunity to ask any questions I have and have received satisfactory answers. With this knowledge, I voluntarily consent to participate in the remote tele-behavioral health phone/video-conference counseling including but not limited to any care, treatment, and services deemed necessary and advisable, under the terms described herein.

Signature: _____ Date: _____

Witness: _____ Date: _____

The above release is given on behalf of _____because the patient is a minor or has been determined to be incompetent to give medical consent for the following reason(s):

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_____ _____

Signature of Parent/Guardian Date