Cary Office (main): 130 Preston Executive Drive., Suite 202, Cary NC 27513 **Telephone**: (919) 467-7777
Raleigh Office: 9207 Baileywick Road, Suite 203, Raleigh, NC 27615
Greensboro Office: 2709-B Pinedale Rd, Greensboro, NC 27408

INFORMED CONSENT FOR TELEHEALTH SERVICES

This agreement serves as an addendum to the Wynns Family Psychology Mental Health Agreement in place between existing clients of WFP and their WFP clinician(s), when telehealth services are requested. All rights, responsibilities and privileges discussed in the Mental Health Agreement remain in force for services conducted using telehealth. Please read, complete the questions, and sign below, acknowledging that you have agreed to the following items:

Platforms

- Your provider will provide you with a link to a video-conferencing platform selected for the scheduled virtual sessions.
- Once you have clicked on the link, you will check into the virtual waiting room by typing your name. Your provider will then initiate the session when they are available.
- The client is responsible for providing and maintaining all equipment required for using telehealth sessions from their locations.
- If you have a technical difficulty, or need to contact your provider for any reason, please email or call them directly.
- NOTE: WFP providers prefer HIPAA compliant platforms (e.g., Doxy, Google Meets, etc.); however, in the event a HIPAA compliant platform is not accessible during this time due to the COVID-19, the client understands and accepts the additional risks regarding privacy/ security that comes from using a non-HIPAA (FaceTime, Skype, V-see, phone/ audio only) compliant platform.

Security and Confidentiality

- The laws that protect confidentiality still apply for telehealth services. In addition, the mandatory and permissive expectations to confidentiality, including but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and compliance with court orders, still apply.
- Nobody will record the session without the written permission from the others person(s).
- You are responsible for the confidentiality and privacy of your own environment during a telehealth session. Please be mindful of your surroundings and consider who might be able to view, hear, or access (whether authorized or not) your information. It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session. If you are in a more "public" area, it is recommended that you use headphones/ earbuds to help maintain privacy.
    - Parents of children or teens: Please find a private, quiet space for your child to have sessions. Please allow them to close the door and have the family give space during their session, so they feel comfortable talking openly. They may be more comfortable wearing headphones or earbuds. If weather permits and they have a safe place to go, they may also want to go outside for sessions.
- There are potential benefits and risks of video-conferencing (e.g., limits to patient confidentiality) that differ from in-person sessions. There are risks and consequences from telehealth, including, but not

limited to, the possibility, despite reasonable efforts on the part of my provider, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted or intercepted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

Missed Appointments

- It is important to be on time. If you need to cancel or change your tele-appointment, you must notify your provider in advance by phone or email.
- As noted in the mental health agreement, WFP has a 48-hour cancellation policy. The "late cancel" or "no-show" fees are outlined in the Mental Health Agreement.

Appropriateness of Telehealth

- Please keep in mind that telehealth sessions may not be an appropriate method of treatment for all clients or all presenting concerns. The authorization to conduct a telehealth session in place of a scheduled in-office session is solely at the discretion of your provider. If you have questions about whether your specific situation is appropriate for telehealth services, please contact your provider. In the event your provider believes you would be better served by another modality of psychotherapeutic or evaluation services (e.g., face-to-face), you will be referred to a clinician who can provide such services.
- At the start of each session, the client must confirm their current physical location.
- You understand your provider will not hold a tele-appointment while you are driving.
- In the event of a telephone-only session, the client must confirm their identity as requested by the provider (e.g., provide full name, DOB, address, etc.).

Insurance

- Although WFP is out of network with all insurance providers, it is recommended that you confirm with your insurance company that the telehealth-sessions will be reimbursed if that is of concern to you.

Payment

- We request clients place a credit card on file before having a telehealth appointment. You may call our office to provide credit card information or fax a credit card authorization form to our office at: (855) 797-9587. Clients without a credit card on file are expected to pay before each session using the Wynns Family Psychology website http://wynnsfamilypsychology.com

AUTHORIZATION

I,_____ (Person filling out form),

on behalf of_____ (Client's name),

hereby consent to engage in telehealth services with Kristen Wynns, Ph.D., owner of Wynns Family Psychology, and/or one of the professionals contracting with Kristen Wynns, PhD/Wynns Family Psychology.

I understand that telehealth includes consultation, treatment, testing, transfer of medical data, and education using interactive audio, video, and/or data communications. I understand that telehealth involves the transmission of my medical/mental information, both orally and visually, to health care practitioners located in North Carolina.

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

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care of treatment, nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
2. The laws that protect the confidentiality of my medical information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to researchers or other entities shall not occur without my written consent.
3. I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted or intercepted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.
4. I understand that telehealth based services and care may not be as complete as face-to-face services. *I also understand that if my psychotherapist believes I would be better served by another modality/form of psychotherapeutic or evaluation services (e.g. face-to-face services) I will be referred to a provider who can provide such services in my area*.
5. I understand the potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my provider, my condition may not improve, and in some cases may even get worse.
6. I understand that recording of the telehealth session at any time by either party is strictly prohibited unless written permission is provided.
7. I understand I am responsible for the privacy of my own environment during telehealth sessions.
8. I understand that I have a right to access my medical information and copies of medical records in accordance with North Carolina law.

I have read and understand the information provided above. I have discussed it with my provider, and all of my questions have been answered to my satisfaction.

Client Signature: _____ Date _____

If the client is a minor:
Signature of Parent/Guardian/Personal Representative: _____

Relationship to Client: _____ Date _____