Tele-mental Health Informed Consent

I, _____, hereby consent to participate in tele-mental health with,

_____, as part of my treatment. I understand that tele-mental health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are in two different locations.

I understand the following with respect to tele-mental health:

- I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.
- I understand that there are risks, benefits, and consequences associated with tele-mental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.
- I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization except where the disclosure is permitted and/or required by law.
- I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to tele-mental health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).
- I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms, or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that tele-mental health services are not appropriate, and a higher level of care required.
- I understand that during a tele-mental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at this number: _____to discuss since we may have to reschedule.
- I understand that my clinician/staff may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

Emergency Protocols

I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life-threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

My emergency contact person's name, address, phone: _____

_____

I have read the information provided above and discussed it with my clinician/staff. I understand the information contained in this form and all my questions have been answered to my satisfaction.

_____

Signature of client/parent/legal guardian Date

_____

Signature of clinician/staff Date

RECOVERY TECHNOLOGY L.L.C.

Service Orientation Checklist

Client Name: _____ Case #: _____

Please check all that apply:

I have chosen the following service(s):

- ☐ Individual Therapy
- ☐ Case Management
- ☐ Anger Management
- ☐ Assertive Community Treatment
- ☐ Integrated Dual Diagnosis Treatment
- ☐ Psychiatric
- ☐ Other

- ☐ I have been educated on the service(s) I have chosen and had a chance to ask questions.
- ☐ I have been informed that the Internal Recipient Rights Advisor for Recovery Technology is Andra Antczak at 796-4520.
- ☐ I was trained on the emergency preparedness plan (fire, tornados, bomb threats, assaults with weapons, aggressive behaviors and how to use the fire extinguishers and emergency exits.)
- ☐ Self-determination was explained to me, and I was given the choice to participate or not.
- ☐ Quality Improvement was explained to me, and I was invited to be a member of the Advisory Board Committee (ABC).
- ☐ The clinician discussed with me the importance of keeping appointments and participating in services scheduled. **I understand that if I miss 3 appointments I may be discharged from the service.**
- ☐ If treatment is court ordered, the requirements for follow-up and discharge have been explained to me.

Client/Guardian Signature: _____

Date

Witness: _____

Date

Therapy Participation Agreement

Client Name: _____ Client #: _____

Psychotherapy can be an effective treatment for a variety of mental health conditions and concerns. It can assist you in developing new coping skills that will empower you to overcome the stressors and symptoms that prevent you from enjoying life to its fullest.

Effective therapy, however, is different than a doctor's appointment. Effective therapy depends greatly on your active participation in the therapeutic process and development of a strong therapeutic relationship with your therapist. For this reason, it is imperative to attend and participate in therapy sessions on a regular basis.

At Recovery Technology we ask that you miss no more than 2 appointments per any 3-month period that you are in services with us. **Missing any more than 2 appointments within 3 months will result in discharge from services**. We understand that at times unforeseen circumstances may prevent you from participating in your scheduled sessions. If you are unable to keep an appointment with your therapist, we request that you cancel no later than 24 hours prior to the scheduled appointment**. If you do not cancel prior to 24 hours, your absence will be considered a missed appointment**.

If you are discharged from therapy services due to missed appointments or due to not responding to our attempts to reach you after a missed appointment**, you will not be able to return to therapy services at Recovery Technology until a period of at least one year past the date you are discharged**. If you wish to return to therapy services after one year has passed, your return may be considered but it is not guaranteed and may require negotiation.

By signing below, I acknowledge that I understand and agree to the above attendance conditions.

Client/Guardian Signature: _____

Date

Witness Signature: _____

Date

Communication and Message Consent Form

Client Name: _____ Case #: _____ Date: _____

We, at RECOVERY TECHNOLOGY LLC, are committed to safeguarding the privacy and confidentiality of your records including the personal information that you provide us. We comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

From time to time, it may be necessary or desirable to contact patients by phone **or text**. To expedite your health care and in the interest of convenience, if you are not available to speak with us directly, we would like to leave a message whenever possible.

To assist us in protecting your privacy, please complete the following:

- ☐ I **DO NOT** want to have detailed messages left with another person who could answer my phone.
- ☐ I **DO NOT** want to have detailed messages left on my voicemail.
- ☐ I **DO NOT** want to be texted with appointment reminders.
- ☐ I **DO NOT** want to receive phone calls with appointment reminders.
- ☐ I **DO NOT** want to receive phone calls at my place of employment.

TEXT MESSAGING INFORMATION

How we will use text messaging: We use these methods to communicate only about non-sensitive and non-urgent issues. All communications to or from you may be made a part of your medical record. You have the same right of access to such communications as you do to the remainder of your medical record. Your text messages may be forwarded to another RECOVERY TECHNOLOGY LLC staff member as necessary for appropriate handling. We will not disclose your text messages to researchers or others unless allowed by state or federal law. Please refer to our Notice of Privacy Practices for information as to permitted use of your health information and your rights regarding privacy matters.

Risk of using text messages: The use of text messages has a few risks that you should consider. These risks include, but are not limited to, the following:

- Texts can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
- Senders can easily misaddress a text and send the information to an undesired recipient.
- Employers and on-line services have a right to inspect texts sent through their company systems.
- Texts can be intercepted, altered, forwarded or used without authorization or detection.
- Texts can be used as evidence in court.
- Text messaging may not be secure, and therefore it is possible that a third party may breach the confidentiality of such communications.

Conditions for the use of text messages:

RECOVERY TECHNOLOGY, LLC cannot guarantee but will use reasonable means to maintain security and confidentiality of text information sent and received. You must acknowledge and consent to the following conditions (by signing below):

- **IN A MEDICAL EMERGENCY, DO NOT USE TEXTING, CALL 911.**
- If you have an urgent problem during regular business hours, please call your case manager or outpatient therapist, or 517-780-3336. Urgent messages or needs should be relayed to us by using regular telephone communication.
- You should speak with your case manager or therapist to discuss complex and/or sensitive situations rather than using text messages regarding such situations.

- Text messages may be filed electronically into your medical record.
- Clinical staff will not forward your identifiable texts to outside parties without your written consent, except as authorized by law.
- You should use your best judgment when considering the use of text messages for communication of sensitive medical information. **Clinical staff are not responsible for the content of messages.**
- RECOVERY TECHNOLOGY, LLC is not liable for breaches of confidentiality caused by you or any third party.
- It is your responsibility to follow up with staff if warranted.

I UNDERSTAND THAT STANDARD CELL PHONE RATES AND TEXT MESSAGING RATES WILL APPLY TO ANY MESSAGE RECEIVED FROM RECOVERY TECHNOLOGY. I UNDERSTAND THAT I MAY REVOKE THIS CONSENT AT ANY TIME. MY REVOCATION OF CONSENT WILL NOT AFFECT MY ABILITY TO OBTAIN FUTURE HEALTH CARE NOR WILL IT CAUSE THE LOSS OF ANY BENEFITS TO WHICH I AM OTHERWISE ENTITLED.

THIS CONSENT DOES NOT EXPIRE UNLESS SPECIFICALLY REVOKED BY THE CLIENT/GUARDIAN.

Client/Guardian Signature: _____

Date

Witness Signature: _____

Date

Informal Complaint Process

Date: _____

Client Name: _____ Case #: _____

If you have any questions or concerns regarding your services at Recovery Technology, please call one of the following phone numbers for assistance. If you are unhappy with the outcome of your informal complaint, please contact a member of Recover Technology's management team or if referred by LifeWays, you may contact LifeWays Customer Service.

For Recovery Technology:

Clinician's Name:_____	Phone: _____
Recovery Technology Receptionist	517-780-3336
Recovery Technology CEO/Management	517-780-3336
Recovery Technology Recipient Rights Advisor	517-796-4520

If referred by LifeWays:

LifeWays Customer Service	517-780-3332

Client Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Notice of Privacy Practices

Receipt and Acknowledgment of Notice

Client Name:_____ Case#:_____

DOB: _____ Date: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of RECOVERY TECHNOLOGY LLC's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Recipient Rights Officer Andra Antczak at (517) 796-4520.

Client/Guardian Signature: _____

Date

Personal Representative Signature: _____

(If applicable) Date

If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

_____

☐ Consumer/Patient Refuses to Acknowledge Receipt:

Signature of Staff Person:_____

Date