Hornstein, Platt & Associates™
COUNSELING & WELLNESS CENTERS OF PHILADELPHIA
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Telehealth Policy and Procedures

Name: Date of Birth: MM/DD/YYYY

Informed Consent: Telehealth/Telemedicine

Please read and sign this document. Questions may be addressed to Dr. Robin Hornstein at rthphd@yahoo.com or 215-732-6308 (Option 1).

Hornstein, Platt and Associates, in an effort to meet the needs of our consumers, is now offering Telemedicine/Counseling. The use of electronic communications helps people who are at a different location than their provider to access clinical care for a variety of issues. The providers are licensed in the State of PA and Florida and may offer services to consumers residing in those states and attending services while located in the state. The process will include your provider gathering your demographic information, and conducting the same therapy that would happen in person, including diagnosing, counseling, consultation with other people in your team and referral to other levels of care and other types of services when in your best interest. Starting in Telemedicine is a joint decision by you and your provider, if it is a good match for your care. It requires two way, encrypted audio and video programs.

Network and software security will be used to protect your confidentiality and identification. While the highest level of technological services will be used, you need to understand the following:

1. While you are at a remote site, you will still need to allow your provider to speak to other members of your health care team. I understand that this consultation will be different than being in the same room as my provider.
2. There is the possibility that things can go wrong with the program and it could preclude correct diagnosis at the time of the session. Your provider will guide you in how to handle this situation.
3. Delays could occur due to network issues out of the control of the provider.
4. Using Technology does not guarantee that information is not intercepted by those unauthorized to have this information. Our technology ensures that we are up to date with security systems that reduce the probability of this happening, but it is not 100% possible to protect this information as we could in person.
5. You may need to move to an in person counseling model if your situation changes due to location, diagnosis requiring in person visit(s) or if it is determined by you or the provider that this style of counseling is not the best for you at this time. Or if this is part of our inclement service,you will continue to be primarily seen face to face.

Your signature on this form indicates that you understand the following information and are in agreement with it:

1. Privacy and confidentiality are the same for telehealth as they are for in-person therapy. However, the laws of reporting that bypass confidentiality also apply including, but not limited by a clear and present danger to yourself or someone else or where you release your mental information in a court of law or other legal situation.
2. My records will be treated the same as in any therapy situation and I may request they be sent to another provider for continuity of care just as I may in formal in-person situations. Copies and summaries will be charged a fee as is consistent with any other records request.
3. I am aware that I may terminate my use of telehealth at any time if I believe I need a different form of care. I will discuss this with my provider the same way I would in face- to-face therapy.
4. My chart may be electronically transferred at my request or due to reasons as described above to other providers to assist in my care. I agree and understand that my information may be shared with other individuals for scheduling and billing purposes. I understand billing may come from another site than I and/or my provider is located at and agree to that condition.
5. I have had alternatives to telemedicine explained to me and understand the differences between the

choices. I have taken under consideration that this may not be the best type of treatment for me and I may not feel better. Should that be true, my provider will work with me to find alternative care. Even with current research indicating that there are few differences between face-to-face care and telehealth, there may be a difference for me that is not helpful in my case. Should that be the case, I will be referred to the best treatment for me. Additionally, as in any care, there is no guarantee that this will work.

6. I agree to follow the advice of my counselor should I need emergency care and, if I need anything further, based on the treatment modality or my own issues, I will call 911 if needed. My counselor and I will come up with a plan for emergency issues.
7. I will show my drivers license as an identifier at the request of my counselor each time it is requested.
8. Fees associated with telehealth are payable by Credit or Debit cards only. While some insurance companies cover this service, some do not. My therapist and I will determine if i am eligible for coverage or will need to revert to private pay for this service.
9. My rights under telehealth:
    a. I may withdraw my consent at any time.
    b. I may need to follow my providers suggestions should I need emergency care. While they can suggest the nearest ER room and they can call my ER contact, I am responsible for knowing the closest crisis response area. I will provide my address where I am located,if different then the address in my chart, so my provider can call 911 if necessery
    c. Telehealth does not guarantee outcomes any different than face to face services.

Consent:
I have read and agree to the above form and all of the delineated items. I have discussed this form with my Counselor. I agree that I am giving informed consent for the use of telemedicine. I authorize and Hornstein, Platt and Associates to use Telehealth with me for my care.

Client Signature: ✍ Date: MM/DD/YYYY