CareConnected

After reviewing this document, please sign, fold, and mail back FORM C ONLY, in the included pre-paid postage envelope. Once this document has been received, you will be contacted by Care Connected staff to schedule your first appointment.

FORM A-INFORMED CONSENT

This form provides me (the patient) with information that is additional to that detailed in the Notice of Privacy Practices and it is subject to HIPAA pre-emptive analysis.

Introduction: Telephonic Cognitive Behavioral Therapy (TeleCBT) is the provision of distance psychological services through a technology-assisted environment, including: telephone, images, audio, telephone, fax, email, Internet and data through an interactive video, telephone connection, or video conferencing. It is important that you be aware that Wisconsin state and federal laws and professional standards that apply to regular psychological services apply to TeleCBT services. Prior to receiving TeleCBT treatment and related services at Care Connected, it is important for you to have an understanding of what these services involve and to freely agree to participate in them. TeleCBT services provided through Care Connected include consultation, counseling, and psychotherapy services with a TeleCBT trained, licensed psychologist, licensed professional counselor, or marriage and family therapist, over the phone. It is important that in considering this service, you understand that phone sessions have limitations when compared to in-person sessions. You must also take into consideration that TeleCBT is not appropriate if you are experiencing a crisis or having suicidal or homicidal thoughts and/or intent. In an effort to determine whether TeleCBT is appropriate for your needs, please be aware that Care Connected TeleCBT providers will conduct an initial assessment to determine whether you can benefit from this service. If at the time of your initial assessment it is determined that you require mental health services, other than TeleCBT, you will be provided with appropriate referrals to meet your needs. Also, you may decline any TeleCBT services at any time without jeopardizing access to future care, services, and benefits. Please review the information in this document thoroughly.

Confidentiality: All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your (the patient) written permission, except where disclosure is required by law. In addition to the explanation of confidentiality provided in this informed consent packet, the law requires Care Connected to provide you with an official **Notice of Privacy Practices.** This notice is provided separately, as part of this intake packet.

In Workers' Compensation claims (as opposed to personal insurance or cash payment), there are different rules regarding confidentiality. In order to receive treatment through your Work Comp insurance carrier, we must submit written reports on a regular basis providing information on your symptoms, the progress of your treatment, and the treatment plan. Additionally, in Workers' Compensation, there is a treatment team, which includes (but is not limited to) the insurance company, adjuster, lawyers, doctors, or other Workers' Compensation providers. As part of your care, we often collaborate with your treatment team. There is the possibility that we will share information and reports with the providers on your treatment team. In this way, you do not have the same privacy as a non-Workers' Compensation client. If you have questions or concerns about this, please do not hesitate to discuss them with us.

When Disclosure Is Required By Law: I understand that Care Connected TeleCBT providers are considered mandated reporters under Wisconsin law, and as such, under the law, and regardless of what form of communication I use in working with my provider, my provider may be required to report certain information to the authorities. I understand that all incidents of actual or suspected child abuse or neglect, elder abuse, and dependent adult abuse fall under the mandated reporter law. The law also requires that

incidents of threatened harm to self or others be reported. Additional instances include where I present as a danger to myself, to others, to property, I am gravely disabled or when my family members communicate to my provider that I am presenting as a danger to others.

When Disclosure May Be Required: Disclosure may be required pursuant to a legal proceeding by or against me. If I place my mental status at issue in litigation initiated by myself, the defendant may have the right to obtain the TeleCBT records and/or testimony by my provider. I authorize the release of any information pertaining to me determined by my provider, my other health care providers or by my insurance carrier to be relevant to the consultation(s) or processing of insurance claims, including but not limited to my name, Social Security number, birth date, and clinical or medical record information.

Health Insurance & Confidentiality of Records: Disclosure of confidential information may be required by my health insurance carrier in order to process the claims. If I instruct my provider, only the minimum necessary information will be communicated to the carrier. Medical data has been also reported to be legally accessed by enforcement and other agencies.

Litigation Limitation: Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither I (the patient) nor my attorneys, nor anyone else acting on my behalf will call on my provider to testify in court or at any other proceeding, nor will a disclosure of the TeleCBT records be requested unless otherwise agreed upon.

Consultation: My provider consults regularly with other professionals regarding his/her patients; however, patient identity remains completely anonymous, and confidentiality is fully maintained.

E - Mails, Cell phones, Computers and Faxes: When providing TeleCBT services, Care Connected will adhere to confidentiality as indicated by the Health Insurance Portability and Accountability Act (HIPAA). However, please understand that unless both the TeleCBT provider and the participant are using landline phones, the conversation is not confidential. Our TeleCBT providers will make every possible effort to ensure your confidentiality, and thus, will always contact you through the Care Connected landline phone. In general, computers, e-mail, and cell phone communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. E-mails, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. Care Connected e-mails are not encrypted; however, computers are equipped with firewall and virus protection, a password, and confidential information on company computers is regularly backed up. I will notify my provider if I decide to avoid or limit in any way the use of any or all communication devices, such as e-mail, cell-phone or faxes.

Records and Your Right to Review Them: Both the law and the standards of my providers profession require that my provider keep appropriate treatment records for at least 7 years. If I have concerns regarding the treatment records I will discuss them with my provider. I understand that I am ordinarily guaranteed access to my medical records and that copies of records of consultation(s) are available to me on my written request. I also understand, however, that if my provider, in the exercise of professional judgment, 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 may have to pay a reasonable fee to get a copy. Additionally, I understand that my records may be used for TeleCBT 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.

The Process of Therapy/Evaluation and Scope of Practice: Participation in therapy can result in a number of benefits to me, including improving interpersonal relationships and resolution of the specific concerns that led me to therapy. Working toward these benefits, however, requires effort on my part. TeleCBT requires my very active involvement, honesty, and openness in order to change my thoughts, feelings and/or behavior. My provider will ask for my feedback and views on my therapy, its progress, and other aspects of the therapy, and will expect me to respond openly and honestly. Sometimes more than one approach can be helpful in dealing with a certain situation. During evaluation or therapy, remembering or talking about unpleasant events, feelings, or thoughts can result in me experiencing considerable discomfort or strong feelings of anger, sadness, worry, fear, etc. It is also possible that I may experience psychological distress, including, but not limited to, anxiety, depression, insomnia, etc. My provider may challenge some of my assumptions or perceptions or propose different ways of looking at, thinking about, or handling situations, which can cause me to feel very upset, angry, depressed, challenged or disappointed. TeleCBT may result in decisions about changing behaviors, employment, substance use, schooling, housing or relationships. Sometimes a decision that is positive for one family member is viewed negatively by another family member. Change will sometimes be easy and swift, and sometimes it may be slow and frustrating. There is no guarantee that TeleCBT will yield positive or intended results. During the course of wellness meetings, my provider is likely to draw on various approaches for the purpose of enhancing my treatment and to assist me in achieving my treatment goals. Wellness approaches include, but are not limited to, behavioral, cognitive and educational.

I understand that I can choose not to answer a question at any time. Any refusal to participate in the consultation(s) will not affect my continued treatment, and that no action will be taken against me. I acknowledge that diagnosis depends on information, and treatment depends on diagnosis, so if I withhold information, I assume the 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.

Discussion of Treatment Plan: Within a reasonable period of time after the initiation of treatment, my provider will discuss with me his/her working understanding of the problem, treatment plan, therapeutic objectives and his/her view of the possible outcomes of treatment. If I have any unanswered questions about any of the procedures used in the course of my therapy, their possible risks, my provider's expertise in employing them, or about the treatment plan, I will ask and will be answered fully. I will also have the right to ask about other treatments for my condition and their risks and benefits. If I could benefit from any treatment that my provider does not provide, he/she has an ethical obligation to assist me in obtaining those treatments.

Termination: I understand that at any time, my TeleCBT services can be discontinued either by me or by my designee or by my health care providers. If I choose to discontinue services, my provider will assist me in finding names of other qualified professionals whose services I might prefer. If at any point during TeleCBT my provider assesses that he/she is not effective in helping me reach the goals, he/she is obligated to discuss it with me and, if appropriate, to terminate treatment. In such a case, my provider will give me a number of referrals that may better suit my needs. If at any time I want another professional's opinion or wish to consult with another therapist, my provider will assist me in finding someone qualified upon my request, and with my written consent, will be able provide him/her with the essential information needed.

Dual Relationships: Not all dual or multiple relationships are unethical or avoidable. Therapy never involves any other dual relationship that impairs my provider's objectivity, clinical judgment or can be exploitative in nature. My provider will assess carefully before entering into non-exploitative dual relationships with clients. My provider will discuss with me the often-existing complexities, potential benefits and difficulties that may be involved in dual or multiple relationships. Dual or multiple relationships can enhance trust and

therapeutic effectiveness, but can also detract from it. It is my responsibility, to communicate to my provider, if the dual or multiple relationships become uncomfortable for me in any way. My provider will always listen carefully and respond accordingly to my feedback, and will discontinue the dual relationship if found it is interfering with the effectiveness of the therapy or the welfare of the client and of course, I can do the same at any time.

Cancellation: Since the scheduling of an appointment involves the reservation of time specifically for me, I acknowledge there is a minimum of 24 hours (1 day) notice for re-scheduling or canceling an appointment. I understand that TeleCBT services are 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 possibilities that the technology will fail before or during the consultation, that the transmitted information in any form will be unclear or inadequate for proper use in the sessions, and that the information will be intercepted by an unauthorized person or persons. The alternatives to TeleCBT services will be 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 services. I understand that TeleCBT services do not necessarily eliminate my need to see a specialist in person, and I have received no guarantee as to the consultation's effectiveness. I understand that I am not entitled to royalties or to other forms of compensation for participation in the TeleCBT services.

Telephone and Emergency Procedures: Potential benefits of TeleCBT include increased accessibility to psychological care. Possible disadvantages of TeleCBT include varying time zones, cultural differences, language barriers, unexpected phone service problems, and strength of Internet connection, which may impact the delivery of services. As a TeleCBT participant, I may provide off-line contact information in case of a technology breakdown, or if reconnection is not possible once a call is unexpectedly interrupted. Also, I understand that Care Connected TeleCBT providers are available during business hours, (type in business hours & workdays). If I need to contact my provider between sessions, I understand that I can leave a message on the answering service 858-249-8565, and my call will be returned as soon as possible and during business hours. This voicemail box will be checked a few times throughout the day, on workdays.

If there is an emergency during our work together, or in the future after termination where my provider becomes concerned about my personal safety, the possibility of me injuring someone else, or about receiving proper psychiatric care, he/she will do whatever he/she can within the limits of the law, to prevent me from injuring myself or others and to ensure that I receive the proper medical care. This includes contacting local authorities in my area of residence in an effort to ensure my safety and the safety of others.

My Responsibilities as a TeleCBT Participant: With regard to emergencies, I acknowledge 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 TeleCBT services. Instead, I will seek care immediately through my own local health care provider or at the nearest hospital emergency department or by calling 911. I agree to inform my TeleCBT provider immediately, if I should experience a mental health emergency situation during a TeleCBT session. Mental health emergency situations include, but are not limited to, the experience of hallucinations and/or delusions, suicidal and/or homicidal thoughts or intent, thoughts about causing harm to yourself or others. If, at any time, I should experience a mental health or life-threatening emergency, I agree to call 911, a local mental health crisis hotline, to access the free National Suicide Prevention Hotline at 1-800-273-8255, or to go to a local hospital emergency room.

Form B-NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. IT SHOULD BE REVIEWED WITH CARE.

Care Connected TeleCBT Providers and their associates are required by federal and state law to maintain the privacy of your health information, as well as give you this notice about privacy practices, legal obligations, and your rights concerning your health information, "Protected Health Information" (PHI). TeleCBT Providers and their associates must follow the privacy practices that are described herein and these practices may be amended as needs or requirements change. For further clarification of anything noted in this document please contact Care Connected TeleCBT at 858-249-8565.

When providing TeleCBT services, Care Connected will make the best possible effort to adhere to confidentiality as indicated by the Health Insurance Portability and Accountability Act (HIPAA). However, please understand that unless both the TeleCBT provider and the participant are using landline phones, the conversation is not confidential. Our TeleCBT providers will make every possible effort to ensure your confidentiality, and thus, will always contact you through a landline phone. In general, computers, e-mail, and cell phone communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. E-mails, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all e-mails that go through them. Care Connected e-mails are not encrypted; however, computers are equipped with firewall and virus protection, a password, and confidential information on company computers is regularly backed up. I will notify my provider if I decide to avoid or limit in any way the use of any or all communication devices, such as e-mail, cell-phone or faxes.

Uses and Disclosures of Your Protected Health Information: The following will explain the ways in which your health information may be used ***without your consent*** under Federal and State law. In all cases, TeleCBT Providers practices disclosing minimum information necessary to achieve the purpose of said disclosure. This is not intended to be an exhaustive list, but instead an explanation of cases and scenarios where disclosure of PHI may be necessary falling under general categories. These disclosures exclude psychotherapy notes as described in the next section.

Treatment: TeleCBT Wellness Providers and their associates may use and disclose information related to your treatment to members of your current treatment team for the purposes of continuity of care and to coordinate and manage your healthcare and related services.

Payment: TeleCBT Wellness Providers and their associates may use and disclose information in your protected health record for billing purposes with your insurance plan. Your insurer may require certain information about your treatment prior to authorizing payment for services.

Health Care Operations: These include quality improvement activities, consultation with colleagues, licensing, and credentialing activities.

In the event of an emergency your protected health information may be disclosed in order to allow for your treatment and care.

When required by law, your protected health information will be disclosed.

Uses and Disclosures Requiring your Written Consent:

Notes recorded by TeleCBT Providers and their associates, documenting the contents of your session (Session

Notes), will be used only by your wellness providers and will not otherwise be used or disclosed without your written authorization. Marketing activities will never include your protected health information without your written approval. Any disclosure to individuals not directly involved in your treatment or care (i.e.: your attorney, school, etc.) will require your written authorization for release of PHI.

Note: Your "authorization" to release PHI may be revoked at any time by providing that the revocation is in writing. This revocation will go into effect when the written notice has been personally received and reviewed.

Your Rights Regarding Your Health Information:

Right to Inspect and Copy: You have the right to inspect and copy your medical and billing records, but not your psychotherapy notes. All requests of this nature must be made in writing. There will be a fee associated with copying records and mailing records if you chose to receive them via mail.

Right to Request Confidential Communications: You have the right to request that TeleCBT Wellness Providers and their associates communicate with you only in a certain location or through a certain method (i.e. at work only, or through email, etc.) All requests must be received in writing and reasonable requests will be honored. A reason for the request is not necessary, but we do need to know the specifics on where and how you wish to be contacted.

Right to Request Restrictions: You have the right to request a restriction on the health information that is used or disclosed about you for treatment, payment, or health care operations. Requests for restrictions must be submitted in writing. We are not required to agree with your requested restriction, however, TeleCBT Wellness Providers and their associates will honor your request unless the restricted health information is needed to provide you with emergency treatment.

Right to Accounting of Disclosures: You have the right to request to be provided with an accounting of the disclosures that have made of your protected health information. This request must be made in writing and will not include disclosures made for the purposes of treatment, payment, and health care operations.

Right to Request an Amendment: You have the right to request amendment of your health information. Your request must be made in writing and should detail the reason for the requested amendment. This request may be denied in certain circumstances.

Right to a Paper Copy of this Notice: You have the right to obtain a paper copy of this Notice of Privacy Practices at any time.

Questions or Complaints: Any questions or complaints regarding your privacy rights should be addressed with the Privacy Officer, TeleCBT Wellness Provider. You may also contact the Secretary of the U.S. Department of Health and Human Services. You will not be retaliated against should you chose to complain to TeleCBT Wellness Providers and their associates, or an outside agency.

This notice is effective April 14, 2003. It may be amended at any time, and the revision will be effective for all PHI maintained. In the event of an amendment, a new notice will be posted and you may request a copy of the revised notice.

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FORM C-Consent to Participate in Care Connected TeleCBT Services

(After reviewing and signing this document, please fold and mail back THIS PAGE ONLY (FORM C) in the included pre-paid postage envelope).

I, _____, have read and understand all information included in this informed consent packet **(Form A).** I confirm that I have also been provided with a **Notice of Privacy Practices (HIPAA) (Form B).** I agree to and understand the parameters of confidentially indicated in this packet **(FORM A AND B),** and concede to the inclusions and exclusions of the services rendered through TeleCBT by Care Connected. I authorize for protected health information related to my medical, mental health, and health care to be electronically transmitted in the form of images, audio, telephone, fax, email, internet and data through an interactive telephone connection to my provider, other persons involved in my health care, and the staff operating the consultation equipment.

I represent that I am using my own equipment to communicate and not equipment owned by another, and 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 consultation and of their purpose for attending the consultation. Based on the information included in this informed consent packet, I have a good understanding of how TeleCBT services are performed and how they will be used for my treatment. I understand how the services differ from in-person services, including but not limited to, emotional reactions that may be generated by the technology.

I understand that my TeleCBT provider will adhere to the ethical practice and legal guidelines set forth by the American Psychological Association (psychologists), Wisconsin Department of Safety and Professional Services (Psychologists and MFTs), the state of Wisconsin, and U.S. federal laws. I understand I must reside in the state of Wisconsin to receive these services. I have a clear understanding that my provider will not be physically in my presence. Instead, we will hear each other electronically. Some information my provider would ordinarily get in face-to-face consultation may not be available through TeleCBT. I understand that such missing information could, in some situations, make it more difficult for my provider to understand my problems and to help me with my mental health needs.

My signature below indicates that I have read the Informed Consent (Form A) and the Notice of Privacy Practices (HIPAA) (Form B). I understand them and agree to comply with them and would like to proceed with my TeleCBT sessions.

Please provide the phone number you wish to be contacted at when receiving TeleCBT services in the space provided below. You may also provide a contact number that your TeleCBT provider can use in the event that there is a problem connecting to your preferred contact number, or in case of an emergency. Care Connected staff has my permission to leave confidential messages at the contact phone numbers I have provided below.

_____ _____

TeleCBT Preferred Contact Number **Alternative/Emergency Contact Number**

_____

Name of Alternative/Emergency Contact and Relationship

_____ _____ _____

YOUR NAME **SIGNATURE** **DATE**