The Arc of Monmouth
Health Services
1158 Wayside Rd.
Tinton Falls, NJ 07712

The Arc
of Monmouth

To Whom It May Concern:

This letter confirms your recent inquiry regarding psychiatric and/or behavioral health services at the Arc clinic. We are requesting the information checked below as this will allow us to best understand and serve your needs. Please return all paperwork via fax, email, or post mail as soon as possible, so that we may be able to add you to our waiting list or schedule your appointment with our team.

Please return this packet in its entirety as well as:

- ☐ A copy of your insurance cards (front & back)
- ☐ Determination of legal guardianship document
- ☐ Most recent bloodwork
- ☐ Any additional assessments that would be beneficial such as:
  - NJ-ISP (NJ Individualized support plan
  - NJ Comprehensive Assessment tool (NJ-CAT)
  - Inidvidualized Education Plan (IEP)
  - Individual Habilitation Plan (IHP)
  - Medical specialist reports
  - Neurological report

Please send this information to mpiantanida@arcofmonmouth.org, or via confidential fax at 732-493-2413. Please contact Maria Piantanida, Director of Health Services, if you have any questions or concerns regarding this paperwork at x881.

The Arc of Monmouth

Mental Health Intake Form

Please complete this form and bring it with you to the first visit.

You may also fax to the Arc of Monmouth at **732-493-3714** or email it to **keenan@arcofmonmouth.org**.

Name_____ Date_____

Date of Birth_____

Legal guardian: ☐ Self ☐ Other- Name:_____Relationship_____

(Please attach determination of legal guardian letter)

Formal diagnoses previouslv given (developmental, metal health, medical):

_____

_____

_____

What are the Problems for which you are seeking help?

1. _____
2. _____
3. _____

Current Symptoms Check All That Apply:

( ) Depressed mood	**( ) Racing thoughts**	**( ) Anxiety attacks**
( ) Impulsivity	**( ) Impulsivity**	**( ) Avoidance**
( ) Unable to enjoy activities	**( ) Risky behavior**	**( ) Hallucinations**
( ) Sleep pattern disturbances	**( ) Decreased sleep**	**( ) Suspiciousness**
( ) Loss of interest	**( ) Excessive energy**	**( ) Fatigue**
( ) Concentration/forgetfulness	**( ) Increased irritability**	**( )_____**
( ) Excessive feelings of gui t	**( ) Crying spells**	**( )_____**
( ) Thoughts of hurting others	**( ) Excessive worry**	**( )_____**
( ) Thoughts of self-harm		

Legal History: Have you ever been arrested? _____ Date(s)_____

Do you have any pending legal problems? _____

Medical History:

Primary Care Physician _____ Phone Number_____

Allergies _____ Height_____ Weight_____

Please List All Current Medications or Attach Medication List, include over the counter medications:

Medication Name	**Daily Dose**	**Date Started**

Please check if you currently have or previously had care from the following providers:

☐ **Neurologist - Name**: _____

Agency/affiliation: _____ Phone:_____

☐ **Cardiologist- Name:** _____

Agency/affiliation: _____ Phone:_____

☐ **Gastrologist/GI - Name**_____

Agency/affiliation: _____ Phone:_____

☐ **Hematologist -Name:** _____

Agency/affiliation: _____ Phone:_____

☐ **Psychiatrist-** Name: _____ Dates seen: _____

Agency/affiliation: _____ Phone:_____

☐ **Mental Health Therapist-** Name: _____ Dates seen: _____

Agency/affiliation: _____ Phone:_____

☐ **other -- Specialty** _____

Name: _____ Agency: _____ Phone:_____

☐ **other -- Specialty** _____

Name: _____ Agency: _____ Phone:_____

Other relevant Current and Past history not addressed (i.e. hospitalizations, surgeries, major behavior changes, life events):

Is there anything else you would like us to know?

Signature _____

Guardian Signature _____

Emergency Contact _____

FOR OFFICIAL USE ONLY:

Reviewed by _____ **Date** _____

Refer To:

☐ **Psychiatry** ☐ **behavioral**

☐ **Psychotherapy** ☐ **other** _____

The Arc.
of Monmouth

New Patient Information Form

Patient name: _____ DOB: _____

Address: _____

Guardian: _____ Email: _____

Pharmacy: _____ Number: _____

Support Coordinator/DDD Case Manager:

Name: _____

Phone: _____

Email: _____

Day Program/School:

Name of program/school: _____

Contact person: _____

Phone: _____

Email: _____

Residential Information (if individual resides in a group home/supervised apartment only):

Name of agency/residence: _____

Contact person: _____

Phone: _____

Email: _____

The Arc of Monmouth
Health Services

AUTHORIZATION FOR ELECTRONIC COMMUNICATION

As a convenience to me, and in order to participate in telehealth sessions, I hereby request communication regarding my treatment via electronic communications (e.g., email). I understand that this means information such as my appointments, diagnosis, progress, and other PHI will be communicated to me electronically.

I understand that there are risks inherent in the electronic transmission of information by email, on the internet, or otherwise and that such communications may be lost, delayed, intercepted, corrupted, or otherwise altered, rendered incomplete, or fail to be delivered.

I further understand that any protected health information transmitted via electronic communications pursuant to this authorization will not be encrypted. As the electronic transmission of information cannot be guaranteed to be secure or error-free and its confidentiality may be vulnerable to access by unauthorized third parties, my psychologist shall not have any responsibility or liability with respect to any error, omission, claim or loss arising from or in connection with the electronic communication of information to me.

After being provided notice of the risks inherent in use of electronic communications, I hereby expressly authorize electronic communication with me, which will include the transmission of my protected health information electronically. I understand that in the event I no longer wish to receive electronic communications, I may revoke this authorization by providing written notice.

I agree to electronic communication unless and until I revoke this authorization by submitting notice in writing. This authorization does not allow for electronic transmission of my protected health information to third parties and I understand I must execute a separate authorization for my protected health information to be disclosed to third parties. I hereby authorize the transmission of my protected health information electronically as described above.

Printed Name	
Signature	Date
Guardian Printed Name	
Guardian Signature	Date

Email Address	
Cell Phone Number	
Guardian Email Address	
Guardian Cell Phone Number	

Smart Phone? □Yes □ No	Computer/Tablet? □Yes □No	Support Person Available, if needed? □Yes □No

Notice of Privacy Practices
Effective 4/14/03

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that providers of health services safeguard patient health information. It is our intention to safeguard the privacy of patients or others served by the Arc by keeping medical information confidential as required by law and as described in Arc's Policies and Procedures. The Arc of Monmouth, in accordance with HIPAA regulations which become effective April 14, 2003, is implementing the following practices.

How We May Use and Disclose Information About You

The following categories describe different ways that we may use and disclose medical information about you without your permission:

1) **For Treatment**

We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students or other medical personnel who are involved in taking care of you. We may also disclose medical information about you to people who need to know in order to properly follow up with your medical care such as staff of the place where you live, family members or others who provide services that are part of your care.

2) **For Payment**

We may use and disclose medical information about you so that treatment you receive at Arc Health Services may be billed to your insurance company. For example, we may submit medical information to our billing company so that they can collect the cost of providing services to you from Medicaid, Medicare or other insurance companies. Submission of this information will be handled as confidential information.

3) **For Operating Activities**

We may use and disclose medical information about you to evaluate our provision of services. This use of information is necessary to make sure that our patients receive quality care. For example, we may review our services and evaluate the performance of our staff in caring for you. We may remove information that identifies you so that others may use it to study how services can be delivered better.

4) **Appointment Reminders**

We may use and disclose medical information to contact you when you have an appointment for treatment or medical care.

5) **Treatment Alternatives**

We may use and disclose medical information about you to explore or recommend possible treatment options or alternatives that may be of interest and beneficial to you.

6) **Individuals involved in your care or Payment for your care**

Using our best judgment, we may release medical information about you to a friend or family member or any other person you identify. With your consent, we may also give information about you to a friend or family member or any other person you identify. We may also give information to someone who helps pay for your care. In addition, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

7) **Research**

Under certain circumstances we may use and disclose medical information about you for educational research purposes. All research projects are subject to a special approval process.

8) **As required by law**

We will disclose medical information about you when required to do so by federal, state or local law.

9) **To avert a serious threat to Health or Safety**

We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

10) **Special Situations**

If you are an organ donor, we may release medical information to organizations involved in the process. If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may disclose medical information about you for public health activities such as: to prevent or control disease; to report abuse, neglect or deaths; or to report reactions to medications. We may disclose medical information about you in response to a court order or subpoena. Efforts will be made to tell you about the request. We may release medical information if asked to do so by a law enforcement official. We may release medical information to a coroner, medical examiner or funeral director as necessary to carry out their duties.

Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission.

Revocation of Permission to Disclose Information

If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures that we had already made with your permission, and that we are required to retain our records of the care we provided to you.

Changes to this Notice

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in a public area. The notice will contain the effective date on the first page.

Your Rights Regarding Your Medical Information

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records and any other records that your physician uses for making decisions about you. We may charge a fee for the costs of supplying these records to you. We may deny your request to inspect and copy records in certain very limited circumstances. If we deny access to medical information, you may request in writing that the denial be reviewed. Your request for review should be directed to:

Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. In addition, you must provide a reason for your request. We may deny your request for an amendment. If we deny your request for amendment, you have the right to file a written statement of disagreement with us.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" other than for treatment, payment or health care operations. It excludes disclosures we may have made to you, to persons involved in your care, or for notification purposes. You have a right to receive specific information regarding these disclosures that occurred after April 14, 2003. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. Your request may not include dates before April 14, 2003.

Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

WE ARE NOT REQUIRED TO AGREE TO YOUR REQUEST. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

Your request must tell us:

- The information you wish to limit;
- Whether you want to limit our use, disclosure or both;
- To whom you want the limits to apply.

Right to Request Confidential Communication: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

TO MAKE A REQUEST, you must put the request in writing to the Director of Health Services. If you have questions about this notice, contact:

Maria Piantanida, RN
Director, Health Services
(732) 493-1919 ext. 881

I HAVE READ AND RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES AGREEMENT AND I AGREE TO ITS TERMS:

Print Name of Patient or Patient's Parent/Guardian: _____

Signature of Patient or Patient's Parent/Guardian: _____

Date: _____

The Arc.
of Monmouth

PSYCHOTHERAPIST-PATIENT SERVICES AGREEMENT

Psychotherapy and Behavior Modification Consent Agreement

This agreement contains important information about our professional services and business Policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a new federal law that provides new privacy protections and new patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the propose of treatment, payment, and health care operations. HIPAA requires that we provide you with a Notice of Privacy Practices for use and disclosure of PHI for treatment, payment and health care operations. The Notice explains HIPAA in greater detail. Although these documents are long and sometimes complex, it is very important that you read them carefully before our next meeting. We can discuss any questions you have about the procedures at that time. When you sign this document, it will also represent an agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on us unless we have taken action in reliance on it; if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

PSYCHOLOGICAL SERVICES

Psychotherapy and behavior modification are not easily described in general statements. It varies depending on the personalities of the psychologist and patient, and the particular problems you are experiencing. There are many different methods we may use to deal with the problems that you hope to address. Psychotherapy is not like a medical doctor visit. Instead, it calls for a very active effort on your part. In order for the therapy to be most successful, you will have to work on things we talk about during our sessions and at home.

Psychotherapy and behavior modification can have benefits and risks. Since thephy often involves discussing and changing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, and helplessness. On the other hand, psychotherapy and behavior modification have also been shown to have many benefits. They often lead to better relationships, solutions to specific problems, and significant reductions in feelings of distress. But there are no guarantees of what you will experience.

If you have questions about our procedures, we should discuss them whenever they arise. If your doubts persist, we will be happy to help you set up a meeting with another mental health professional for a second opinion.

CONTACTING US

As each of the psychologists at Arc's Ambulatory Care center are employed on a part time basis, they are often not in the office or not immediately available by phone. When we are unavailable, you may contact our Office Manager, Linda Tuzenue, at 493-1919 ext. 888. She will take a message and will attempt to reach us to relay your message. If your call is urgent, please contact the Director of Health Services Kristen Creed, at 732-493-1919 ext. 800. **If you are unable to reach us and feel that you can't wait for us to return your call, contact your family physician or the nearest emergency room and ask for the psychologist or psychiatrist on call.**

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a psychologist. In most situations, we can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. **Your signature on this Agreement provides consent for those activities, as follows:**

- The staff of the Ambulatory Care Center work together as a team, and find it helpful to consult with each other about our work with Arc's served individuals. Your case may be discussed in detail with other team members, in order to enhance the treatment you receive.
- We may occasionally find it helpful to consult other health and mental health professionals outside of Arc about a case. During a consultation, we make every effort to avoid revealing the identity of my patient. The other professionals are also legally bound to keep the information confidential. If you don't object, we will not tell you about these consultations unless we feel that it is important to our work together. We will note all consultations in your Clinical Record (which is called "PHI" in the Notice of Psychologist's Policies and Practices to Protect the Privacy of Your Heath Information).
- You should be aware that the Ambulatory Care Center employs administrative staff. In most cases, we need to share protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. Staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.
- We also have contracts with (D.D.D.). As required by HIPAA, we have a format business associate contract with this/these business (es), in which it/they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. If you wish, we can provide you with the names of these organizations and/or a blank copy of this contract.
- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this Agreement.

There are some situations where we am permitted or required to disclose information without either your consent or Authorization:

- If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the psychologist-patient privilege law. We cannot provide any information without your (or your legal representative's) written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order us to disclose information.
- If a government agency is requesting the information for health oversight activities, we may be required to provide it for them.
- If a patient files a complaint or lawsuit against us, we may disclose relevant information regarding that patient in order to defend myself.
- If a patient files a worker's compensation claim related to the services we are providing, we may, upon appropriate request, disclose protected information to others authorized to receive it by the workers' compensation law.

There are some situations in which we are legally obligated to take actions, which we believe are necessary to attempt to protect others from harm and we may have to reveal some information about a patient's treatment. These situations are unusual in our practice.

- If we have reasonable cause to believe that a child has been subject to abuse, the law requires that we must report it to the Division of Youth and Family Services. Once such a report is field, we may be required to provide additional information.
- If we have reasonable cause to believe that a vulnerable adult is the subject of abuse, neglect or exploitation, and we believe that the disclosure is necessary to prevent serious harm to the patient or other potential victims, we will report the information to the Division of Development Disabilities and the county adult protective services provider.

Once such a report is filed, we may be required to provide additional information.

- If a patient communicates a threat, or if we believe the patient presents a threat of imminent serious physical violence against a readily identifiable individual, we may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient.
- If we believe the patient presents a threat of imminent serious physical harm to him/herself, we may be required to take protective actions. These actions may include contacting the police or others who could assist in protecting the patient or seeking hospitalization for the patient.

If such a situation arises, we will make every effort to fully discuss it with you before taking any action and we will limit my disclosure to what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and we are not attorneys. In situations where advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPAA, The Arc of Monmouth maintains a set of Clinical Records. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that we set for treatment, your progress towards those goals, your medical and social history, your treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records that we receive, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances that involve danger to yourself and others or when another individual (other than another health care provider) is referenced and we believe disclosing that information puts the other person at risk of substantial harm, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, we recommend that you initially review them in the presence of one of our therapists, or have them forwarded to another mental health professional so you can discuss the contents. (We are sometimes willing to conduct this review meeting without charge.) In most situations, we are allowed to charge a copying fee per page (and for certain other expenses.) The exceptions to this policy are contained in the attached Notice Form. If we refuse your request for access to your Clinical Record, you have a right of review, which we will discuss with you upon request.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that we amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about our policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form, and our privacy policies and procedures. We are happy to discuss any of these rights with you.

MINORS, PARENTS AND GUARDIANS

Patients under 18 years of age who are not emancipated and their parents, and patients over 18 years of age who have a legal guardian should be aware that the law may allow parents and guardians to examine their child's treatment records unless we decide that such access is likely to injure the child, or we agree otherwise. Because privacy in psychotherapy is often crucial to successful progress, particularly with teenagers, it is sometimes our policy to request an agreement from parents and guardians that they consent to give up their access to their child's records. If they agree, during treatment, we will provide them only with general information about the progress of the child's treatment, and his/her attendance at scheduled sessions. We will also provide parents/guardians with a summary of their child's treatment when it is complete. Any other communication will require the child's Authorization, unless we feel that the child is in danger or is a danger to someone else, in which case, we will notify the parents of my concern. Before

giving parents/guardians any information, we will discuss the matter with the child, if possible, and do our best to handle any objections he/she may have.

INSURANCE REIMBURSEMENT

In order for us to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. We will fill out forms and provide you with whatever assistance we can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of our fees. It is very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Of course, we will provide you with whatever information we can based on my experience and will be happy to help you in understanding the information you receive from your insurance company. If it is necessary to clear confusion, we will be willing to call the company on your behalf

Due to the rising costs of health care, insurance benefits have increasingly become more complex. It is sometimes difficult to determine exactly how much mental health coverage is available. "Managed Health Care" plans such as HMOs and PPOs often require authorization before they provide reimbursement for mental health services. These plans are often limited to short-term treatment approaches designed to work out specific problems that interfere with a person's usual level of functioning. It may be necessary to seek approval for more therapy, after a certain number of sessions. While much can be accomplished in short-term therapy, some patients feel that they need more services after insurance benefits end. Some managed-care plans will not allow us to provide services to you once your benefits end. If this is the case, we will do my best to find another provider who will help you continue your psychotherapy.

You should also be aware that your contract with your health insurance company requires that we provide it with information relevant to the services that we provide to you. An insurance company or other third-party payer regulated under New Jersey law may request that the patient authorize the psychologist to disclose certain confidential information to the third-party payor in order to obtain benefits, *only* if the disclosure is pursuant to a valid authorization (see below) and the information is limited to:

1) Administrative information (i.e., patient's name, age, sex, address, educational status, identifying number, date of onset of difficulty, date of initial consultation, dates and character of sessions (individual or group), and fees);
2) Diagnostic information (i.e., therapeutic characterizations as found in the APA's Diagnostic and Statistical Manual of Mental Disorders (DSM III), or other professionally recognized diagnostic manual);
3) The patient's status 9voluntary or involuntary; inpatient or outpatient);
4) The reason for continuing psychological services, limited to an assessment of the patient's current levels of functioning and distress (both described by terms of mild, moderate, severe or extreme);

5) A prognosis, limited to the estimated minimal time during which treatment might continue.

A valid authorization under this statute shall:

1) Be in writing;
2) Specify the nature of the information to be disclosed, the person authorized to disclose the information, to whom the information may be disclosed, the specific purposes for which the information may be used, both at the time of disclosure and at any time in the future;
3) Specify that the patient is aware of the his or her right to confidential communications under psychologist-patient privilege;
4) Be signed by the patient, or the person authorizing disclosure (e.g., the patient's parent, guardian or legal representative);
5) Contain the date that the authorization was signed.

If the third-party payor has reasonable cause to believe that the psychological treatment in question may be neither usual, customary nor reasonable, the third-party payor may request, in writing, and compensate reasonably for, an independent review of such treatment by an independent review committee.

You should be aware that if your health benefits are provided by a self-insured employee benefit plan or other arrangement regulated by the federal ERISA statue, such plan will have considerably more access to information in your Clinical Record. They will not have access to your Psychotherapy Notes. If you have any question about the nature of your health benefits, you should contact the group that provides the benefits for you.

This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. We will provide you with a copy of any report we submit, if you request it.

Once we have all the information about your insurance coverage, we will discuss what we can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. It is important to remember that you always have the right to pay for my services yourself to avoid the problems described above (unless prohibited by contract).

Your signature on the sign off page indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

The Arc.
of Monmouth

I have received a copy of the Psychotherapist-Patient Service Agreement in compliance with HIPAA regulations.

Name: _____

Signature: _____ Date: _____

Witness: _____

The Arc of Monmouth
Health Services

TELEHEALTH

"Telehealth" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications, meaning that you and your therapist are not in the same room during telehealth consultations and psychotherapy sessions. If you agree to take part in telehealth sessions you acknowledge:

1. There are potential risks to the use of telehealth technology despite all reasonable efforts being taken to avoid them, including interruptions in transmissions, access by unauthorized indiv duals and technical difficulties. You r therapist or you may discontinue any telehealth sessions if you feel that that the audio or video connection is inadequate for the situation or otherwise compromised.

2. In order to participate in telehealth sessions you will need to have access to a quiet, private location where your confidentiality, and any other participants' confidentiality (in the case of group sessions), will be upheld and interruptions will be limited.

3. During sessions you will be asked to turn off any TV or radios and refrain from engaging in otherwise distracting activities like reading, using the computer, texting, etc.

4. Your health care information provided and exchanged during a telehealth session may be shared with others for scheduling, billing, or other lawful purposes and that those individuals are required to maintain confidentiality, as with in-person services.

5. You have had the alternatives to telehealth explained to you.

6. There is no recording of the session by either your therapist or you, though your therapist will keep notes and written records as they do with face-to-faces sessions.

7. Telehealth sessions are to be scheduled with regularity just as with face-to-face sessions and it is the responsibility of both your and your therapist's responsibility to inform the other of any needs for cancellation or rescheduling in a timely manner.

8. Telehealth services are not available as a means of crisis management or in emergency situations.

9. You insurance will be billed for telehealth sessions in the same manner as if the visits were in person.

10. You have been given the opportunity to discuss telehealth options and platforms with your therapist and to ask any questions that you have about this option.

11. Your questions have been answered to your satisfaction and the risks, benefits, and any practical alternatives have been explained.

Telehealth services rely on a number of electronic, often internet-based technology tools, such as, videoconferencing software, email, text messaging, smartphone technology, and virtual environments. By agreeing to participate in telehealth you agree to electronic communications. Please see the Authorization for Electronic Communications Form for more information.