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Child & Family Psychological Services, Inc./Psychological Care Associates
ADDENDUM TO AGREEMENT RELATED TO TELEHEALTH SERVICES
(Updated 3/10/2020)

In this addendum, we review relevant information about our professional services and policies as they pertain to telehealth services. To better serve the needs of patients, health care services are now available by interactive video communications to patients at a distant location. Telehealth may be used in the evaluation, diagnosis, management, and treatment of a number of health care problems.

Since telehealth services may be different than the type of consultation with which you are familiar, it is important that you understand and agree to the following:

1. I understand that the health care provider will be at a different location from me, and that telehealth may include electronic communication of my personal health information. The health care provider has explained to me how the video conferencing technology will be used to provide appropriate services and discussed how this service will differ from a direct, in-person visit.

2. I understand there are potential risks to utilizing this technology despite reasonable efforts by the health care provider, including, but not limited to, unforeseen interruptions in service, unauthorized access to electronic data, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consultation if the videoconferencing connections are not adequate for the situation. I have also discussed what to do if I experience technical difficulties or my telehealth session is unexpectedly interrupted.

3. I have had a direct conversation with the health care provider, during which I had the opportunity to ask questions about telehealth services. My questions have been answered and the risks, benefits, and any practical alternatives have been discussed with me in a language in which I understand. I understand that I have the option to refuse telehealth services at any time without affecting my right to future care or treatment. I also understand that telehealth services may not be recommended by my provider, may not appropriate for all patients, or available in all locations.

4. I understand that because the health care provider may be distant and/or unfamiliar with the local area, they may be unable to provide adequate emergency assistance. In case of a crisis or emergency arising in which someone is in danger, I agree to take whatever precautions and steps necessary to maintain safety, including dialing 911 and/or going to the nearest emergency room.

5. I understand the laws and standards of the health care provider's profession requires that they keep Protected Health Information about me in their Clinical Record, which apply equally to in-person and telehealth services. The content of telehealth consultations is not recorded in any fashion, nor are they monitored or stored by any entity.

6. I understand the legal, regulatory, and ethical rules governing confidentiality and privileged personal health information also apply to telehealth services. Federal HIPAA regulations further require that special technological precautions be taken when any identifiable Personal Health Information is transmitted over the internet. I understand that despite CFPS/PCA's full compliance with these regulations and great efforts to secure any and all electronic personal health information, it is possible the transmission and storage of my personal health information could be interrupted or accessed by unauthorized persons. I have spoken with my health care provider directly about confidentiality in the context of telehealth services and had an opportunity to ask questions and raise concerns.

7. I understand that laws and regulations vary in each state and that the provider may not be able to provide telehealth services when I am in certain states. I understand the laws pertaining to limits of confidentiality,

mandated reporting, duty to warn, and involuntary hospitalization also vary by jurisdiction at time of service. I agree to specifically inform the provider what state I will be in at the time of service when the appointment is scheduled.

8. I understand that CFPS/PCA clinicians may not be licensed in the state in which I am participating in services, if such states do not require such a licensure, or allow for a temporary licensure or temporary practice. Likewise, I understand the number of visits the clinician can provide while I am outside of Massachusetts may be limited depending on what state I am in at the time of the service amongst other factors.

9. I understand that telehealth services are intended to be used adjunctively with in-person services whenever viable and not replace in-person services. Similarly, telehealth services are not intended as a replacement for cancelled or missed appointments. My provider may require in-person visits at certain frequencies.

10. I agree to not record, save, publish, disseminate, or electronically transmit any data, images, video, audio, and/or any other aspect of the telehealth and/or videoconferencing service.

11. I understand that I am responsible for securing a quiet, comfortable, and private space suitable for telehealth services. I am also responsible for supplying enough technological resources, knowledge of how to use the necessary software and equipment, and time to set up for, and participate in, telehealth services.

12. I understand that the CFPS/PCA cancellation and no-show policy applies to telehealth services. Technological problems on the patient/recipient's end preventing scheduled services are treated the same as un-kept appointments and billed accordingly to our general services agreement. Please be sure to test the connection, software, hardware, and equipment prior to the appointment to ensure their functionality and allow for troubleshooting. I understand that should services be interrupted by technological problems on the clinician's end, or with the video-conferencing platform itself, no cancellation or no-show fees will be incurred.

13. I understand that violating these policies may be grounds for termination of care.

Please sign and return one complete copy of this form and keep a copy for your own records.

I understand that this agreement is an addendum to the Services Agreement previously reviewed and signed.

I have read the statements above, understand the guidelines, and agree to them completely in my consent for services for myself or my child. I understand that I have the right to legal counsel before agreeing to these terms.

_____

Patient Name (please print)

_____ _____

Signature of adult patient or parent Date

_____ _____

Signature of second parent/guardian Date