

Northern Wellness Counseling, LLC
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Telemental Health Informed Consent

Provision of mental health services over electronic communications, also referred to as Telemental Health or Distance Therapy Services, can provide an efficient and effective way to engage in therapeutic services that have traditionally occurred face-to-face in an office setting. Telemental health is the delivery of mental health services using interactive technologies (use of audio, video or other electronic communications) between a practitioner and a client who are not in the same physical location. The following summarizes the information you need to know in order to determine whether you wish to supplement your experience at my practice through telemental health.

Risks: Telemental health is a new delivery method for professional services, and is not fully validated by research. There may be potential risks, including some risks not currently recognized. Among the known risks is the possibility the technology could fail during the session, the transmitted information could be unclear or inadequate due to technical issues, and the information could potentially be intercepted by unauthorized person(s). It is also possible that security protocols could fail, resulting in a breach of privacy of personal health information (PHI).

Unauthorized Access to Electronic Transmissions: To the extent Nathalia Grauvogel is able, telemental health sessions will be considered and treated with the same degree of privacy and confidentiality as in-office sessions. However, telemental health has some limits to confidentiality as a result of the electronic means required to provide the service. These services rely on technology which allows for greater convenience in service delivery. There are risks in electronic transmission of information including, but not limited to, breaches of confidentiality, theft of PHI, and disruption to sessions due to technical difficulties.

Location: Nathalia Grauvogel is a licensed professional counselor in the State of Alaska, license #852. Practice is limited to clients in the State of Alaska at this time.

Records: In accordance with state law, client records are maintained and archived for a period of seven (7) years following termination of counseling services as identified by the last therapeutic session of record.

Limits of Confidentiality: Confidentiality is also as defined in the client treatment agreement.

Potential Limits Impacting Service Delivery: When providing distance therapy services, a variety of issues may impact service delivery. These include, but are not limited to:

time zone differences (I am located in the Alaska Time Zone, GMT- 9); differences in local customs, cultural and language differences may impact services delivered.

Insurance for Telemental Health or Distance Therapy: In 2016, Alaska enacted a law expanding the use of telemedicine in the state. This law authorizes the use of telemedicine (also known as telemental health and distance therapy) in certain clinical practices including counselors. In addition, Alaska enacted a law requiring insurance plans in Alaska to cover telemental health services the same as in-person mental health services and without the need for a prior in-person visit between the health care provider and patient. As a Licensed Professional Counselor, my services are covered by most insurance providers, **however it is your responsibility to determine if outpatient out of network mental health and telemental health services are covered by your insurance plan. Ultimately you are responsible for any balance not covered by your insurance provider.**

Client initials/date _____/_____

Emergency or crisis procedures: In emergencies, in case of service disruption, or for other routine administrative purposes, it might be necessary to communicate by other (non-video) means.

Client Phone number:

By signing below I understand my practitioner and I will regularly reassess the appropriateness of continuing to deliver services to me through the use of the technologies we have agreed upon today. We will modify our plan as needed. As a result of the distance involved, some therapeutic interventions that my provider might provide in-person may not be available. I also recognize my provider will not be able to render any emergency assistance if I experience a crisis.

Emergency Care: 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 agree to seek care immediately through my own local health care practitioner or at the nearest hospital emergency department or by calling 911. These are the names and telephone numbers of my local emergency contacts (including local physician; crisis hotline; trusted family, friend, or adviser).

Emergency contact #1 name and relationship

Telephone number

Emergency contact #2 name and relationship

Telephone number

If a need for direct, in-person services arises, it is my responsibility to contact Nathalia Grauvogel's office for an in-person appointment or my primary care physician if Nathalia Grauvogel is unavailable. I understand an opening may not be immediately available in either office, or that due to distance involved it may be more appropriate for me to seek emergency care. Emergency care practitioners in my area I could contact include:

Name of health care provider in my community

Telephone number

I have discussed local support services that may be available in case of an emergency. I am aware my practitioner may contact the proper authorities and/or my designated, local contact person in case of an emergency.

I acknowledge I have read and understood the above description of the risks and responsibilities involved with telemental health participation. With this knowledge, I voluntarily consent to participate in the telemental health treatment.

Authorized email address (please print): _____

Printed Client Name: _____

Client signature: _____ Date: _____

Legal Guardian Name: _____

Legal Guardian signature: _____ Date: _____

Legal Guardian Name: _____

Legal Guardian signature: _____ Date: _____