Family
Wellness Associates

Hi there!

As we discussed, I am now using thera-LINK, a secure video service for online sessions. I chose thera-LINK because it's very user friendly. That said, there are some very important things you'll need to know in order to avoid the potential frustration of not being able to connect at our scheduled appointment time.

I've added you as a client on thera-LINK. **The system automatically generated an email that contains a link that you MUST click on to accept the invitation and join thera-LINK**. When you click the link, you'll create your password and type in some other information. That first email might go to your junk/spam/clutter file, so go ahead and look for that at your earliest convenience.

As soon as you have your log in information, you can log into thera-LINK. The dashboard will list your appointment details after I schedule it with a green join button that is available 2 hours prior to your appointment. The portal also has a menu on the left called support, which can further answer any questions.

If you're using a PC, Mac, or Android device, **please use Chrome, Firefox, or Safari version 12.2 or greater**. If you are using an iPhone or iPad, use **Safari 12.2 or higher**.

Rebooting your computer before a session is a good idea especially if you've used other applications during the day that utilize your speakers/camera/microphone - not required but it's often helpful with some systems.

Once you've logged in, you can click on the settings menu to upload a picture of yourself if you'd like. thera-LINK auto detects your time zone and your appointments will be displayed accordingly.

Finally, keep in mind that when using thera-LINK, the more bandwidth you have available, the better your connection will be. Therefore, if you're planning on using a phone or tablet, connecting to Wi-Fi will vastly improve the session.

Disconnections may occur. If we get disconnected, I'll restart the session on my side. If you don't see me in a few minutes, go back to the Dashboard and click the green join button again. I will call you if more than 5 minutes have elapsed.

I'm looking forward to meeting with you using this technology. If you have any questions, feel free to call me.

Initial: for approval of using Teleheath: OPT OUT_____ IN:_____

Email address:_____

Therapist Name:_____

Sincerely,

Dr. Capers

Family Wellness Associates

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INFORMED CONSENT ADDENDUM FOR ONLINE THERAPY

This form is designed to allow you to give informed consent for the use of video technology for online therapy. Read it thoroughly for understanding and ensure all of your questions are answered before signing to give consent.

This is to be used in conjunction with, but does not replace, the Informed Consent document that is required of all clients prior to starting therapy services.

Online therapy or teletherapy is defined as the use of technology to have a therapy session. We will use thera-LINK, a HIPAA compliant platform that uses video and audio technology through a webcam on your device and my device to connect us securely.

thera-LINK uses encrypted data streams (AES-256) for our video sessions. Any data that is stored outside of our video session on the thera-LINK platform (such as documents, messages, or progress notes) is encrypted and meets or exceeds all HIPAA and HITECH guidelines.

The benefits of teletherapy include the convenience of location, time, wait times, and accessibility which allows for better continuity of care. In addition, teletherapy allows for greater accessibility to services for clients with limited mobility or with lack of transportation. Teletherapy can also allow for couples or families to meet when in different locations.

With all technology, there are also some limitations. Technology may occasionally fail before or during our session. The problems may be related to internet connectivity, difficulties with hardware, software, equipment, and/or services supplied by a 3rd party. Any problems with internet availability or connectivity are outside the control of the therapist and the therapist makes no guarantee that such services will be available or work as expected. If something occurs to prevent or disrupt any scheduled appointment due to technical complications and the session cannot be completed via online video, the therapist will either use the in-session video chat to trouble shoot or will call you back to complete the session. Please list your main number and an alternate number here: _____.

If, for any reason, we are unable to connect and you are in an immediate crisis or a potentially life-threatening situation, get immediate emergency assistance by calling 911.

I AGREE TO TAKE FULL RESPONSIBILITY FOR THE SECURITY OF ANY COMMUNICATIONS OR TREATMENT ON MY OWN COMPUTER AND IN MY OWN PHYSICAL LOCATION. I understand I am solely responsible for maintaining the strict confidentiality of my user ID and password and not allow another person to use my user ID to access the Services. I also understand that I am responsible for using this technology in a secure and private location so that others cannot hear my conversation.

I understand that there will be no recording of any of the online session and that all information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without my written permission, except where disclosure is required by law.

I understand that I am not allowed to do any recording, screenshots, etc. of any kind, of any session, and are grounds for termination of the client-therapist relationship.

Consent to Treatment

I, voluntarily agree to receive online therapy services for an assessment, continued care, treatment, or other services and authorize Family Wellness Associates to provide such care, treatment, or services as are considered necessary and advisable. I understand and agree that I will participate in the planning of my care, treatment, or services and that I may withdraw consent for such care, treatment, or services that I receive through Family Wellness Associates at any time. I understand Family Wellness Associates will determine on an on-going basis whether the condition being assessed and/or treated is appropriate for online therapy.

By signing this Informed Consent, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

Email Address:

_____

Therapist Name:

_____

_____

Patient/Client Signature

_____

Parent, Guardian or Legal Representative Signature
(if minor or needed otherwise)

_____

Date

Sincerely,

Dr. Capers

Family Wellness Associates

Health Insurance Portability and Accountability Act (HIPAA) - PRIVACY NOTICE

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

In this Privacy Notice, "medical information" and "psychological information" mean the same as "health information." Health information includes any information that relates to:

1) your past, present, or future physical or mental health or condition;
2) providing health care to you; or
3) the past, present, or future payment for your health care.

Protecting Your Privacy:

Counselors must always manage psychological records with great concern for privacy and confidentiality. I am required by law to protect the privacy of your health information. This means that I will not use or disclose your health information without your authorization except in the ways I tell you in this notice. If I wish to use or disclose your health information in ways other than those stated in this notice, I will ask you for your written authorization. If you give such an authorization, you may revoke it at any time, but I will not be liable for uses or disclosures made before you revoked your authorization.

Although the security of psychological records has continuously been addressed by Counseling Codes of Ethics as well as by State and Federal laws, the rules have been considerably strengthened by the provisions of the Health Insurance Portability and Accountability Act (HIPAA). The following information provides details about the provisions of HIPAA and your rights concerning privacy and your psychological records.

Who will observe these rules?

In my practice, the following individuals are required by HIPAA to comply with the privacy rules:

- Me and any practice staff such as office manager/scheduler, etc..
- Any billing agency or collection agency that handles information about you (name and address, diagnostic codes, treatment codes, and consultation dates...but not actual clinical records)

YOUR RIGHTS REGARDING PSYCHOLOGICAL INFORMATION ABOUT YOU:

1. The Right to Inspect and Obtain a Copy of Your Psychological Record

Professional records constitute an important part of the therapy process and help with the continuity of care over time. According to the rules of HIPAA, your consultations are documented in two ways: 1) The Clinical Record (required), which includes the date of your consultations, your reasons for seeking therapy, your diagnosis, therapeutic goals, treatment plan, progress, medical and social history, treatment history, functional status, any past records from other providers, and any reports to your insurance carrier; and 2) Psychotherapy Notes (optional), which consist of specific content or analyses of therapy conversations (some of which may include sensitive information you have revealed that is not required to be included in your Clinical Record) and therapist's notes that may assist in treatment. Psychotherapy Notes, if created, are never disclosed to third parties, HMOs, insurance companies, billing agencies, patients, or anyone else. If your case manager or insurance company requests to see the psychotherapy notes, you have a choice about consenting (signing a Release of Information form) or denying access to them. If you refuse, it will not affect your coverage or reimbursement in any way, and your insurance company or HMO is obliged to provide payment, as usual.

2. The Right to Request a Correction or Add an Addendum to Your Psychological Record Correction
3. The Right to an Accounting of Disclosures of Your Psychological Information to Third Parties
4. The Right to Request Restrictions on How Your Information is Used
5. The Right to Request Confidential Communications
6. The Right to a Copy of This Notice upon Request
7. The Right to Withdraw Permission to Disclose Health Information
8. The Right to File a Complaint You have the right to file a complaint if you believe your privacy rights have been violated. Complaints must be filed in writing, and may be addressed directly to your therapist, or to the Secretary of the Department of Health and Human Services (address: Office for Civil Rights, 200 Independence Ave., S.W. Washington, DC 20201). If you have any questions or concerns about this notice or your health information privacy, please do not hesitate to address them during session or contact my office by telephone.
9. The Right to be Notified in There is a Breach of Your Unsecured PHI You have a right to be notified if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) our risk assessment fails to determine that there is a low probability that your PHI has been compromised.
10. The Right to Restrict Disclosures When You Have Paid for Your Care Out-of-Pocket -

You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for services.

_____ _____

My signature above represents that I have read and understand my rights under HIPAA. Date