SHEEHAN PSYCHOTHERAPY ASSOCIATES

Emergency Procedures & Consent for Behavioral Health Services Delivered via a Remote Technology

Emergency Intervention and Communication

Ideally services are provided in-person, but there are situations in which an in-person service is not possible, and in these instances services will be delivered remotely using available and secure technologies. These instructions are for those instances in which services are delivered remotely.

In the event that you are expressing suicidal or homicidal thoughts, or displaying symptoms of acute mania, psychosis, gross disorganization, acute intoxication, alcohol or other drug withdrawal risk, or describing a crisis that cannot be resolved remotely it may be necessary for me to refer you to a higher level of care, or for me to contact 911 in the case of imminent danger.

Should it be necessary for me to intervene in a life-threatening emergency situation, and you are unable to notify significant others in your life yourself, then I would need to notify the person you identify as your emergency contact. Please provide the name and phone number of the person you would want me to contact in an emergency. Please ensure that the person you name has agreed to serve as your emergency contact in an emergency, and if necessary the emergency contact would agree to assist in getting you transported to the hospital.

Please sign below to indicate that you understand that it may be necessary for me to notify your emergency contact in situations that pose an imminent risk to you or others. So that I can serve you safely and effectively during remote sessions you also agree to inform me of your physical location at the start of each session. Physical location includes: City/ Town, Street Address, Apartment Number, Floor, Suite, or any other information that would be required to direct emergency personnel to your location in the event of an emergency.

Client Signature: _____ Date: _____

Printed Name of Client: _____

If Applicable:

Printed Name of Parent/ Legal Guardian: _____

Signature of Parent/ Legal Guardian: _____ Date: _____

Emergency Contact:

Printed Name of Emergency Contact: _____

Phone Number of Emergency Contact: _____

Please indicate below the Name & Phone Number of your preferred local hospital should it be necessary to refer you for inpatient psychiatric care or medical detoxification:

Hospital Name & Phone#:_____ _____

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In case of Technology Failure:
While there are benefits of remote Telemental Health technology, there is also the possibility that we will run into a technological failure. In the event that this happens, let's try to contact each other via telephone. Please make sure you have a phone with you, and indicate your phone number here: _____

If we are disconnected during a remote session, please disconnect and then restart the session. If we are unable to connect within 5-minutes, I will call you. If you do not hear from me within 10-minutes after a session is prematurely disconnected, please call me at **401-821-6070.**

Verification Requirements:
At the completion of the telephone screening process, if there is agreement that is safe and appropriate for you to receive behavioral health services via a remote telehealth technology, standard operating procedure requires us to verify your identity. The preferred way to do this involves an in-person visit for the first session, during which you would provide us with the following: Valid Picture ID (Driver's License/ State ID Card); Insurance Card, and a Credit/Debit/FSA/HSA/HRA Card.

If it is not possible for the first session to take place in the office, then copies of the above identifying documents must be provided to the office prior to the first session.

If the first appointment is a remote session you will be asked to show a valid photo ID, or another form of identity verification. The purpose of this step is to protect you from the possibility that someone else tries to pose as you.

Consent to Receive Behavioral Health Services Delivered via a Remote Telehealth Technology
Because remote telehealth technologies are continually evolving, it is quite possible that the use of such technologies poses currently unknown risks to the privacy and/or security of your protected health information. As we move forward with the use of remote technologies, feel free to ask questions at any time, and please be assured that your clinician and the administrative staff at this practice will be receptive to your feedback and privacy/ security concerns.

Please print, sign, and date below in order to indicate that you understand and accept the terms of remote technology utilization detailed in this document, and you voluntarily consent to receive behavioral health services that are delivered via a remote telehealth technology.

Client Signature: _____ Date: _____

Printed Name of Client: _____

If Applicable:

Printed Name of Parent/ Legal Guardian: _____

Signature of Parent/ Legal Guardian: _____ Date: _____