MAITRI
MENTAL HEALTH

INFORMED CONSENT ADDENDUM FOR TELEMENTAL HEALTH SERVICES

I _____ [name of client] hereby consent to engaging in telemental health services with Maitri Mental Health as part of my mental health services.

I understand that "telemental health" is defined as the provision of behavioral health services using telecommunication technologies, which may include: delivery, assessment, diagnosis, consultation, treatment, transfer of medical data, and psycho-education using audio, video, or other data communications.

I understand that, by consenting to these services, they may also involve the communication of my mental health information to other health care practitioners as needed/allowed.

I understand that using telemental health services allows access to mental health care that might not otherwise be available to me due to my mental health, and/or my physical, resource, or geographic limitations.

I understand that to receive telemental health services, I must be in one of the following locations within the state of Washington at the time of the service provided: a clinic; a community mental health / chemical dependency setting; a dental office; a federally qualified health center; at home or any location determined appropriate by the individual receiving services; inpatient or outpatient hospital; neurodevelopmental centers; a physician or other health professional's office; a renal dialysis center (except an independent center); rural health clinics; schools; or skilled nursing facilities.

I understand that I will not be provided telemental health services while operating or within a vehicle that is in motion.

TECHNILOGICAL REQUIREMENTS

I understand that I may need to download an application and/or software to engage in telemental health services. My provider and I will how to prepare for telemental health services and I will be expected to do so prior to my telemental health appointment. I also need to have a broadband Internet connection or a smart phone device with a good cellular connection at home or at the location deemed appropriate for services. I understand that in case of technology failure, I may contact Maitri Mental Health via phone at 360-200-4481 to coordinate alternative methods of treatment.

FINANCIAL INFORMATION

Financial Obligations: Fees associated with telemental health appointments are payable by credit or debit card. If fees may be associated with my telemental health services, I agree to have my credit/debit card information on file with Maitri for the billing of such services. These services will be billed on the day of service.
(Client Initial: _____)

Use of Insurance: I am responsible for contacting my insurance company to determine what my out-of-pockets costs may be for telemental health services. I authorize insurance benefits to be paid directly to Maitri Mental Health and that Maitri may release any information to my insurance provider required for processing my claims.
(Client Initial:_____)

Self-Pay Options: I am aware of the fees associated with telemental health appointments (listed below) and agree to pay at the time of my appointment. I understand that I am responsible for cancelled telemental health appointments in accordance with the Maitri Mental Health cancellation policy as documented by my signature on the Informed Consent Form.
(Client Initial: _____)

Fees for Telemental Health Services

Individual Therapy	$120 / intake, $100 / session after
Marriage, Couple, or Family Therapy	$140 / intake, $120 / session after
Group Counseling / Therapy	Fee dependent, to be discussed directly with provider
Late Cancellation/No Show Fees	$100 / late cancellation or no show

Scheduling: I understand that scheduling is conducted through Maitri Mental Health and is based on my provider's normal clinic hours. Telemental health appointments are considered outpatient services and not intended as a substitute for emergency or crisis services. Crisis or mental health emergencies should be directed to the local county crisis line or by dialing 911.

Clark County Crisis Line: 360-969-9560
ProtoCall Services (Greater Portland Area): 1-800-435-2197
National Suicide Prevention Lifeline: 1-800-273-8255

CONFIDENTIALITY WITH TELEMENTAL HEALTH

Limits of Confidentiality: The laws that protect the confidentiality of my medical information also apply to telemental health. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality including, but not limited to: reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. Maitri's telemental health platform is HIPAA-compliant to protect my privacy and confidentiality. This is further explained in the Mental Health Informed Consent, which I have signed. I understand that I am responsible for receiving services at a location that suits my own privacy preferences and that Maitri Mental Health or their providers are not responsible for my decision in this matter.

Video/Audio Recording: As a general practice Maitri Mental Health does not record telemental health sessions without prior permission.

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CLIENT RIGHTS WITH TELEMENTAL HEALTH

I understand that I have the following rights with respect to telemental health:

1. I have the right to withdraw my consent at any time.
2. I understand that there are risks and consequences associated with telemental health including, but not limited to the possibility, despite reasonable efforts on the part of my provider, that the transmission of my medical information could be disrupted or distorted by technical failures. In addition, I understand that telemental health-based services and care may not be as complete as face-to-face services. I also understand that if my provider believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services) I will be referred to a provider who can provide such services in my geographic area.
3. I understand that I may benefit from telemental health services but that results cannot be guaranteed or assured.
4. I understand that Maitri Mental Health may not provide telemental health services to me if I am outside of the State of Washington, and I understand that I may access telemental health services from Maitri Mental Health from within the State of Washington **only**.
5. I understand that I have a right to access my mental health information and copies of medical records in accordance with Washington state law.

I have read and understand the information provided above. I have discussed it with my counselor/therapist/clinical intern, and all of my questions have been answered to my satisfaction. My signature below indicates my informed and willful consent to treatment using this platform.

_____ _____
Client Signature Date

_____ _____
Guardian/Parent Signature Date

_____ _____
Therapist Signature Date