HPA LiveWell

TED

PATIENT ASSENT			
PATIENT NAME:		CELL PHONE #:	
PATIENT SIGNATURE:		DATE:	
PARENT/GUARDIAN CONSENT			
PARENT/GUARDIAN NAME:		PARENT/GUARDIAN PH #:	
PARENT/GUARDIAN SIGNATURE:			
NAME OF THERAPIST:		THERAPIST PH #:	

INFORMED CONSENT & PATIENT ASSENT FOR GROUP TELEHEALTH SERVICES

- Patient and parent/guardian agree to participate in group psychotherapy via telehealth which includes live audio and video. We understand we will see and hear the clinician(s) and other participants and they will be able to see and hear us, just as if they were in the same room.
- Patient agrees to participate in a well-lit private space with no other people, distractions or interruptions. We understand the web cam must always be on.
- We understand that telehealth sessions must maintain appropriate privacy and security requirements, including but not limited to compliance with HIPAA. This means under no circumstance may I record any visual or auditory parts of the telehealth session or discuss the session with anyone other than my therapist. ***If I violate this agreement, I will be legally liable for the breach of confidentiality.***
- We understand that HPA/LiveWell has implemented safety measures to ensure each telehealth session is secure between the participants and no part of group sessions will be recorded.
- We recognize that all participants will be advised of the confidentiality requirements and all participants will be required to also sign this form.
- We understand this group is not individual therapy and is not a replacement for existing therapy or treatment, but an additional support resource. We agree to maintain engagement with individual/family therapy.
- There is a signed Release of Information (ROI) form on file with for patient's individual therapist (if outside HPA/LiveWell).
- We recognize that outcomes and recovery are best achieved when patients participate in group on a consistent basis according to their treatment recommendations.
- If the patient will be participating in a group session at a location other than residence on file, for safety, patient/family must notify clinician of current location at the start of that session.
- We understand a parent/guardian must be accessible by phone during group session in the event the HPA Treatment Team needs to be in touch concerning safety, stability, treatment recommendations and treatment planning.
- We understand that, although rare, technology problems may delay or interrupt a telehealth session. Technology problems will be corrected as soon as possible. If patient is dropped from the session due to an interruption in technology, we will attempt to log back in as soon as possible. If unable to connect, we will immediately contact the HPA Admin Team via email to ***frontdesk@albanyhpa.com***.
- If we have any concerns related to care, we are able and willing to contact either Owner/Director, Dr. Julie Morison or HPA's Administrative Leadership via email at *frontdesk@albanyhpa.com.*
- We understand that we have the right to withdraw this consent at any time, without affecting patient's right to future care or treatment.
- By signing this form, we have read and understand the information outlined, and all our questions have been answered to satisfaction give informed consent to group therapy via telehealth at HPA/LiveWell.

Authorization for Release of Mental Health Information via Electronic Transmission

Patient Information:

Last Name: ________________________ First Name: ________________________ DOB: ___________

Phone: ___________________________ Email: ____

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide *all* information requested may invalidate this authorization.

I AUTHORIZE HPA/LIVEWELL to disclose to (**Person/Provider Information):**

Name: ________________________________ Office: _______________________________________

Relationship: Parent Primary Care Med Provider Dietitian Other: ____________

Email: ________________________________ Fax: ________________ Phone: _____________

Release Information:

Release information of my care for the period of: _______ (Start Date) to _______ (End Date)

Purpose for release of information: ____

I request this authorization to be valid and in effect until: ____________________________ (End Date)

Comments:

I request that health information regarding my care and treatment be released as set forth on this form. I understand I have the right to revoke this authorization at any time by contacting HPA/ LiveWell in writing. I understand the risks of sending this information electronically. All items on this form have been completed, my questions about this form have been answered and I have been provided a copy of this form.

Signature of Patient/Guardian: _______________________________ Date Signed: _______________

Printed Name: ________________________________ If not patient, relationship: ________________