36 Ricketts Drive
Winchester, VA 22601
&
123 Hovetter Drive
Inwood, WV 25428

Winchester Community Mental Health Center, Inc.

Name: _____

MR #: _____

INFORMED CONSENT TO TELEHEALTH

Telehealth allows my medication management and therapist to diagnose, consult, treat and educate using interactive audio, video or data communication regarding my treatment. I hereby consent to participating in medication management and/or psychotherapy via telephone or the video-conferencing (hereinafter referred to as Telehealth).

I understand I have the following rights under this agreement:

I have a right to confidentiality with Telehealth under the same laws that protect the confidentiality of my medical information for in-person medication management and/ or psychotherapy. Any information disclosed by me during my session, therefore, is generally confidential. There are, by law, exceptions to confidentiality, including mandatory reporting of child, elder, and dependent adult abuse and any threats of violence I may make towards a reasonably identifiable person.

I also understand that if I am a danger to myself or others, my healthcare provider has the right to break confidentiality to prevent the threatened danger.

Further, I understand that the dissemination of any personal and/or identifiable images or information from the Telehealth interaction shall not occur without my written consent.

I understand that while medication management and/or psychotherapeutic treatment of all kinds has been found to be effective in treating a wide range of mental disorders, personal and relational issues, there is no guarantee that treatment will be effective. Thus, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.

I further understand that there are risks unique and specific to Telehealth, including but not limited to, the possibility that our telehealth sessions could be interrupted by technical failures.

In addition, I understand that Telehealth treatment is different from in-person therapy and that if my therapist believes I would be better served by another form of psychotherapeutic services, such as in-person treatment, I will be referred to a healthcare provider in my geographic area that can provide such services. I have read and understand the information provided above.

I have the right to discuss any of this information with my healthcare provider and to have questions regarding my treatment answered to my satisfaction.

I understand that I can withdraw my consent to Telehealth communications at any time by providing written notification to WCMHC.

My signature below indicates that I have read this Agreement and agree to its terms.

Client's Signature: _____ Date_____

Parent/Legal Guardian's Signature: _____ Date_____

Clinician Signature and credentials: _____ Date_____

Supervisor Signature and credentials: _____ Date_____

36 Ricketts Drive
Winchester, VA 22601
&
123 Hovetter Drive
Inwood, WV 25428

Winchester Community Mental Health Center, Inc.

Name: _____
MR #: _____

Tele-Therapy and Tele-Medication
Limits of Confidentiality

What is Teletherapy or Telehealth/Tele-Medication?

Teletherapy, Telehealth/Tele-Medication, involves the use of electronic communications to enable physicians and other healthcare professionals, including mental healthcare professionals, to improve the access to quality and appropriate care. Teletherapy includes the practice of health-care delivery, evaluation diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. Treatment Providers may include, but are not limited to, psychiatrists, psychologists, nurses, counselors, clinical social workers, and marriage and family therapists.

Teletherapy services are also available for face-to-face clients on an as needed basis if deemed to be necessary and appropriate for treatment. At this time teletherapy services are only being offered via videoconferencing and the telephone.

Risks and Benefits

In addition to the risks and benefits outlined in the Informed Consent, Teletherapy has its own unique risks and benefits. Benefits include improved access to care for clients who are homebound, lack reliable transportation, or do not have providers near them. Teletherapy can be beneficial for those who are more comfortable communicating online rather than face to face. Teletherapy often offers more flexibility with scheduling. Risks include but aren't limited to: unexpected technological failures during sessions; increased risks to privacy which creates an additional burden on the client to ensure that sessions are private and undisrupted; hacking. An important risk to consider is the lack of nonverbal communication (body signals) that are readily available to both therapist and client in face-to-face sessions. Without this information, teletherapy may be slower to progress or be less effective altogether.

Client Records

All records are kept in written, hard copy form and stored at Winchester Community Mental Health Center located in Winchester, VA or Inwood, WV. All records are stored for seven (7) years. Clients and Parents/Legal Guardians of Minor Clients have the right to request a copy of the record or a brief summary. All records request must be submitted in writing and are subject to a fee.

Verification of Client Identity

At the initial session the client will be required to provide proof of identity.

Technological Failures

Should a video or telephone session experience a disruption/technological failure the therapist will re-establish the connection (place a new video or telephone call) unless other arrangements between client and therapist are agreed upon. If videoconferencing is temporarily unavailable the session will resume via telephone (in accordance with the client's consent for communication form.) If after 15 minutes connection can't be re-established, or the session resumed on the phone then the session will be rescheduled. If the technological failure occurs on the therapist's end the client will not be charged for the appointment; if the failure occurs on the client's end, they are still subject to the full session fee (pro-rated session rates not available).

Emergencies

Emergency procedures laid out in the Informed Consent form apply. Given that therapy is not being conducted face to face, I do require all teletherapy clients have an emergency contact on file (additional release will be provided).

Best Practices

To create an environment that is as close to a face-to-face experience as possible the following guidelines are strongly recommended:

A. Ensure that your location is private and secure. Try to conduct your session in a room that allows you to separate yourself from distractions and any non-participants in the home who might overhear. Make arrangements for childcare if possible.

B. If the session is being conducted through video chat:

a. Make sure there is enough lighting. Dark and solid colored clothing works best and lowers risk of interference with video image. Avoid large pieces of jewelry that reflect light. Take off hats and sunglasses that limit the view of your face.

b. Only use a Wi-Fi network that is secure via password protection, no public Wi-Fi

c. Position yourself and camera so that you are visible from at least the waist up. If there are multiple participants make sure everyone is in view.

I understand that teletherapy services and care may not be as complete as face-to-face services. I also understand that if my therapist believes I would be better served by another form of psychotherapeutic and/or medication management services (e.g. face-to-face services) I will be referred for face-to-face sessions.

I understand that there are potential risks and benefits associated with any form of medication management and/or psychotherapy, and that despite my efforts and the efforts of my medical provider and/or therapist, my condition may not improve, and in some cases may even get worse.

I understand that in the event of an adverse reaction to the treatment, or in the event of an inability to communicate as a result of a technological or equipment failure, I shall seek follow-up care or assistance at the recommendation of my medical provider and/or therapist.

I understand that the laws that protect privacy and the confidentiality of medical information also apply to teletherapy.

I understand that the information disclosed by me during my treatment is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality as outlined in the main informed consent form.

I also understand that the dissemination of any personally identifiable images or information from the teletherapy interaction to researchers or other entities shall not occur without my consent.

I understand that I have the right to withhold or withdraw my consent to the use of teletherapy and/or Tele-Medication during my care at any time, without affecting my right to future care or treatment.

Client Signature: _____ Date: _____

Parent/Legal Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

36 Ricketts Drive
Winchester, VA 22601
&
123 Hovetter Drive
Inwood, WV 25428

Winchester Community Mental Health Center, Inc.

Name: _____

MR #: _____

OUTPATIENT AFTER HOURS EMERGENCY POLICY AND PROCEDURE

POLICY:
If a client's condition deteriorates after program hours to require a level of intensity and security greater than what the Outpatient provides, the client or parent/guardian should call 911 or go to the nearest hospital.

PROCEDURE:
1. Should psychiatric emergency arise after program hours, the client and/or family member and/or significant other may contact the program at (540) 409-0638 at which time the answering service will immediately contact the Program Director. Should life endangering behavior be present, the answering service will immediately notify the caller to contact emergency services 911 or go to the nearest hospital, and may initiate this call if necessary.
2. The Program Director, once notified, will then contact:
a. The client's family member and/or significant other to gather further information on the client's current status, and to take professionally indicated actions.
b. In case of life threatening behaviors, immediate contact with emergency services will be initiated to protect the life and safety of the client and/or others.

CLIENT/GUARDIAN STATEMENT: I have read and fully understand and agree to all conditions to this <u>After Hours Emergency Policy and Procedures.</u>

_____ _____
Signature of Client Date Signature of Parent/Advocate Date

_____
Witness Signature Date

36 Ricketts Drive
Winchester, VA 22601
&
123 Hovetter Drive
Inwood, WV 25428

Winchester Community Mental Health Center, Inc.

Name: _____

MR #: _____

NOTIFICATION OF CLIENT RIGHTS

1. The right to be treated with consideration and the respect for personal dignity, autonomy and privacy; to include freedom from any type or form of abuse, exploitation, retaliation, humiliation and neglect.
2. The right to service in a humane setting which is the least feasibly restrictive, as defined in the treatment plan.
3. The right to be informed of one's own condition, of proposed or current services, treatment or therapies, and of the alternatives.
4. The right to consent to or refuse any service, treatment or therapy upon full explanation of the expected consequences of such consent or refusal. A parent or legal guardian may consent to or refuse any service, treatment or therapies on behalf of a client who is a minor; this includes involvement in research projects.
5. The right to a current, written, individualized service plan that addresses one's own mental health, physical health, social and economic needs, and that specifies the provision of appropriate and adequate services, as available, either directly or by referral.
6. The right to be informed how to access self-help services, legal entities for appropriate representation, and advocacy support services.
7. The right to active and informed participation in the establishment, periodic review, and reassessment of the service plan.
8. The right to freedom from unnecessary or excessive medication.
9. The right to freedom from unnecessary restraint or seclusion.
10. The right to participate in any appropriate and available agency service, regardless of refusal of one or more other services, treatments or therapies, or regardless of relapse from earlier treatment in that or another service, unless there is a valid and specific necessity, which precludes and/or requires the client's participation in other services. This necessity shall be explained to the client and written in the client's current service plan.
11. The right to be informed of and refuse any unusual or hazardous treatment procedures.
12. The right to agency adherence to research guidelines and ethics, if applicable.
13. The right to be advised of and refuse observation by techniques, such as one-way vision mirrors, tape recorders, televisions, movies or photographs.
14. The right to have the opportunity to consult with independent treatment specialists or legal counsel at one's own expense.
15. The right to confidentiality of communication and of all personally identifying information within the limitations and requirements for disclosure of various funding and/or certifying sources, state or federal statutes, unless release of information is specifically authorized by the client, parent or legal guardian of a client who is a minor, or court-appointed guardian of the person of an adult client.
16. The right to be informed in advance of the reason(s) for discontinuance of service provision, and to be involved in planning for the consequences of that event.
17. The right to receive an explanation of the reason(s) for the denial of services.
18. The right not to be discriminated against in the provision of service on the basis of religion, race, color, creed, sex, national origin, age, lifestyle, physical or mental handicap, developmental disability or inability to pay.
19. The right to know the cost of services.
20. The right to be informed and participate in discharge plans.
21. The right to be fully informed of all rights.
22. The right to exercise any and all rights without reprisal in any form, including continued and uncompromised access to service.
23. The right to file a grievance.
24. The right to have oral and written instructions for filing a grievance.

Winchester Community Mental Health Center promotes maximum integration and inclusion of the persons served through regular evaluation of the following: any restrictions placed on the rights or privileges of the persons served; method to reinstate restricted or lost privileges and rights; and the purpose or benefit of any type of restriction on rights or privileges.

Privileges can be lost through violation of program rules, or a failure to demonstrate progress in treatment. Should restrictions on privileges occur, the purpose of the restriction will be fully explained to the client and will be documented in the case record. The consumer will also be informed regarding the methods to reinstate restricted or lost privileges. This will also be documented in the case record. All privilege loss must follow an approved WCMHC Behavior Management Plan.

Please speak with the Clinical Director if you have concerns or problems with any of the Winchester Community Mental Health Center, Inc. policies or staff. We want to serve and provide you with excellent service and respect.

Clinical Director: Mary Zirkle, MS, LPC, (540) 535 – 1112

If you are not satisfied with our solution, or you continue to have problems or concerns, please call your Local Human Rights Advocate.

Human Rights Advocate: Cassie Purtlebaugh, (804) 382 – 3889

All clients have the right to a complaint resolution, hearing, and appeal procedure.

Advanced Directives:

I have received written information regarding my rights to make decisions concerning medical care, including the right to accept or refuse medical treatment, and the right to formulate Advanced Directives under state law.

Client has developed an Advanced Directive: ☐ Yes ☐ No

If client selected "no," stop here and let the member recipient know that assistance in developing an Advanced Directive is available through various national and state resources, such as www.caringinfo.org.

If an Advanced Directive has been executed, it is in the medical record, unless the client does not wish to have it filed.

☐ Client declined Advanced Directives.

The Human Rights have been explained to me and a copy of the Human Rights and Regulations Booklet has been offered to me.

_____

Client OR Parent/Advocate Signature Date

_____

Staff Signature Date

36 Ricketts Drive
Winchester, VA 22601
&
123 Hovetter Drive
Inwood, WV 25428

Winchester Community Mental Health Center, Inc.

Name: _____

MR #: _____

VERBAL COMMUNICATION/CONSENT RELEASE

I, a patient of Winchester Community Mental Health Center hereby give consent for verbal communication by members of my Treatment Team to the following person(s):

Name & Relationship to Patient:_____
Current Address: _____
Current Telephone #(s) _____

Name & Relationship to Patient:_____
Current Address: _____
Current Telephone #(s) _____

Name & Relationship to Patient:_____
Current Address: _____
Current Telephone #(s) _____

Name & Relationship to Patient:_____
Current Address: _____
Current Telephone #(s) _____

LIMITATION: Verbal communication is limited to information regarding my treatment program. This authorization does not authorize dissemination of any portion of my medical record. This authorization is valid for the term of my treatment at Winchester Community Mental Health Center, plus ninety (90) days post discharge; unless revoked by me in writing, prior to that date. I hereby release Winchester Community Mental Health Center and all members of my treatment team from any liability which may arise as a result of information provided per the terms of this authorization.

_____ _____
Signature of Client Date Signature of Parent/Advocate Date

_____
Witness Signature Date

36 Ricketts Drive
Winchester, VA 22601
&
123 Hovetter Drive
Inwood, WV 25428

Winchester Community Mental Health Center, Inc.

Name: _____

MR #: _____

MEDICATION POLICY AND PROCEDURES

1. We WILL NOT replace lost, stolen, or destroyed medications/prescriptions.

2. Calls for prescription refills will be evaluated on an individual basis and determined by the following:
   a. Attendance
   b. Correct usage of medication
   c. Proper notification of refill request. Office requires 5-7 day notice.
   d. Mental health status and stability

3. We will respond to your non-emergency messages within 72 business hours.

4. We will not refill a medication that our office did not prescribe.

5. Failure to notify clinician of all currently prescribed medications will results in discharge.

6. Abuse of medication and failure to keep appointments will result in discharge.

7. Our office will monitor clients if necessary by using the Prescription Monitoring Program**.**

CLIENT/GUARDIAN STATEMENT: I have read and fully understand and agree to all conditions to this Medication Policy and Procedures.

_____ _____

Signature of Client Date Signature of Parent/Legal Guardian Date

_____

Witness Signature Date

36 Ricketts Drive
Winchester, VA 22601
&
123 Hovetter Drive
Inwood, WV 25428

Winchester Community Mental Health Center, Inc.

Name: _____

MR #: _____

CLIENT ORIENTATION

- My rights and responsibilities as a client by this agency, including standards of conduct.
- Policies and procedures include rights of the client as they relate to: confidentiality of information, privacy, freedom from abuse, access to information pertinent to the client, informed consent, access to referrals, and procedures to safeguard and protect records.
- The grievance and appeal procedures of the agency, human rights and how to report.
- The ways in which I can provide my input on the quality of care I receive and my satisfaction with services (i.e. suggestion boxes, satisfaction surveys).
- An explanation of the agency's services, expectations, hours of operation, locations, access to after-hour services, code of ethics, confidentiality policy, limits of confidentiality, and process for follow-up of persons served regardless of the discharge outcome.
- An explanation of any and all financial obligations, fees and financial arrangements for services provided by the agency.
- Familiarization with the premises, including emergency exits and/or shelters, fire suppression equipment, first aid kits, and general information about infection and control policies and procedures.
- The program's policies, as applicable, regarding: the use of seclusion or restraint, smoking, drugs brought into the program, and weapons brought into the program.
- Identification of the person(s) responsible for service coordination.
- A copy of the program rules, if applicable, identifying the following: (1) any restrictions the program may place on the client, (2) events, behaviors or attitudes that may lead to the loss of rights or privileges of the client, and (3) means by which the client may regain rights or privileges that have been restricted.
- Education regarding advanced directives, if appropriate to the program.
- Identification of the purpose and process of the assessment.
- An explanation on the development of my individual service plan and my participation in it. As applicable, legal guardian access to information and participation in treatment planning will be encouraged.
- Information regarding admission, discharge and transition criteria and procedures, if applicable.
- When applicable, an explanation of the organization's services and activities, including: expectations for consistent court appearances; identification of therapeutic interventions, sanctions, incentives and administrative discharge criteria.

I have actively participated in the above **CLIENT ORIENTATION**, and have had all of my questions, in reference to the above items, answered to my satisfaction.

_____

Client OR Parent/Advocate Signature Date

_____

Staff Signature Date

Coordination of Care Form
Winchester Community Mental Health Center, Inc.
36 Ricketts Drive, Winchester, VA 22601
VA Phone: (540)-535-1112 VAFax: (540)-535-1155
WV Phone (304)-901-5801 WV Fax: (304)-901-5458

MR#:_____
CLIENT NAME:_____ **DATE OF BIRTH:**_____

THIS IS NOT A REQUEST FOR RECORDS AT THIS TIME. THIS IS A NOTIFICATION OF CLIENT'S SERVICES AT WCMHC.

READ THIS FIRST:
This form is to be completed if you wish to authorize your behavioral health provider to exchange information regarding your behavioral health condition to your primary care provider or other behavioral health providers who may be directly involved in making decisions regarding your health care. This authorization will remain in effect until the (a) date you specify; (b) one (1) year from date signed; or (c) the date you withdraw your permission.

☐ **I hereby refuse to exchange information with my primary care provider or other behavioral health providers. (If client refuses, have client sign and do not complete the information below).**

Primary Care Physician or group practice name:_____
*(*please indicate if none at this time)*
Phone number:_____ **Fax number:** _____

Client Information
WCMHC Provider: _____ **First date of service:** _____
The client is receiving:

☐ Group therapy
☐ Substance Abuse Treatment
☐ Family Therapy
☐ Intensive Outpatient Therapy
☐ Medication Management
☐ Individual Therapy
☐ Partial Hospitalization Program
☐ Couples Therapy
☐ Intensive In-home services
☐ Mental Health Skill-building services
☐ Relevant information:_____

Complete your acknowledgement that you understand that:

- You have the right to review the information that is being used or disclosed;
- You do not have to complete this authorization and your refusal will not affect your benefits;
- The information used or disclosed by this authorization may be at risk for re-disclosure by the recipient and no longer protected by federal privacy laws;
- It is your responsibility to notify your Behavioral Healthcare Provider if you choose to change your Primary Care Physician;
- You have a right to revoke this authorization at any time.

_____ _____
Signature of Client, Parent, Guardian or Authorized Representative Date

_____ _____
Authorized Staff Signature Date

36 Ricketts Drive
Winchester, VA 22601
&
123 Hovetter Drive
Inwood, WV 25428

Winchester Community Mental Health Center, Inc.

Name: _____

MR #: _____

Provider: _____ **Date:** _____

FALL RISK SCREENING:

Does client have any physical medical conditions that put her/him at risk for falling, such as a seizure disorders, inner ear disorders, hypoglycemia, diabetes, low blood pressure, etc.?

□ No □ Yes **If yes, please explain below and complete a fall risk assessment immediately.**

Explain: _____
_____
_____
_____
_____
_____

Does the client have any medication side effects at prescribed or incorrect dosages that put her/him at risk for falling, such as dizziness, drowsiness, etc.?

□ No □ Yes **If yes, please explain below and complete a fall risk assessment immediately.**

Explain: _____
_____
_____
_____
_____
_____

Does the client have any emotional conditions or behaviors that put her/him at risk for falling, such as not paying attention, engaging in excessive risk-taking, abusing substances, etc.?

□ No □ Yes **If yes, please explain below and complete a fall risk assessment immediately.**

Explain: _____
_____
_____
_____
_____
_____