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Electronic Problem-Solving Treatment (ePST) Informed Consent

ePST Overview:

- As a client receiving behavioral health services through ePST, I understand:
  - ePST is an interactive online treatment for depression and associated mental health symptoms.
  - ePST is self-driven, and does not involve live meetings with a behavioral health provider.
  - ePST consists of 6 "sessions," each lasting about 45 minutes.
  - ePST can be completed at my own pace.
  - My progress and assessments in ePST will be remotely monitored by a Counseling Associates clinician on a periodic basis.

Cost:

- I understand that use of this program requires a $25 fee to cover associated expenses.

Software Security Protocols:

- Electronic systems used will incorporate network and software security protocols to protect the privacy and security of health information, and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption.

Technology Requirements:

- I will need access to, and familiarity with, the appropriate technology in order to participate in the service provided.
- If I am using ePST from home, I am responsible for the technology I am choosing to use.
- Administrative staff at a satellite location will be able to assist me with set up and login as well as any questions that may occur during use of ePST.

Benefits and Limitations:

- ePST is provided by technology and does not involve face-to-face meetings with a provider.
- This service may be utilized on its own or in conjunction with counseling, medication, or other behavioral health services, therefore increasing access to care.
- My therapist will be unable to render any direct emergency assistance if I experience a crisis; they will utilize and contact identified local emergency services and supports if necessary.

Risks of Technology:

- These services rely on technology, which allows for greater convenience in service delivery. There are risks transmitting information over technology that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties.

- I understand that telebehavioral health is a new delivery method for professional services, in an area not yet fully validated by research, and may have potential risks, possibly including some that are not yet recognized.
- Among the risks that are presently recognized is the possibility that the technology will fail before or during consultation, that the transmitted information in any form will be unclear or inadequate for proper use in treatment, and that the information may be intercepted by an unauthorized person or persons.
- In rare instances, security protocols could fail, causing a breach of privacy of personal health information.

Exchange of Information:

- The exchange of information will not be direct and information exchanged may at times be provided through electronic means or through postal delivery.
- During my online treatment, details of my medical history and personal health information may be discussed through the use of online technology.

Local Practitioners:

- If a need for direct, in-person services arises, it is my responsibility to contact practitioners in my area for an in-person appointment.
- I understand that an opening may not be immediately available.

Disruption of Service:

- Should service be disrupted please ask an administrative staff member for assistance.
- The Counseling Associates clinician monitoring your progress may also contact an administrative staff member to assist with correcting any technical difficulties in order to continue your use of ePST.

Modification or Discontinuation of Treatment:

- The clinician monitoring my progress will regularly reassess the appropriateness of continuing to deliver services to through the use of this technology and modify our plan as needed.
- I may decline any telebehavioral health services at any time without jeopardizing my access to future care, services, and benefits.

Release of Liability:

- I unconditionally release and discharge Counseling Associates, its affiliates, agents, and employees as well as ePST and their designees from any liability in connection with my participation in online treatment.

Laws and Standards:

- The laws and professional standards that apply to in-person behavioral health services also apply to online services.
- This document does not replace other agreements, contracts, or documentation of informed consent.

Email:

- In order to take part in ePST it is necessary to provide an email for which you are comfortable receiving your invitation link to participate. Please provide your preferred email below. Providing your email authorizes Counseling Associates to send your meeting invitations to this email.
- Email address: _____

Emergency Protocol:

- In emergencies, in the event of disruption of service, or for routine or administrative reasons, it may be necessary to communicate by other means:
    - In emergency situations you may be contacted by phone and/or your emergency contact may be contacted in order to ensure your safety and wellbeing.
    - In emergency situations it also may be necessary to contact authorities, emergency contact, PCP, and or any other emergency personnel to ensure your safety and well-being.
    - I acknowledge that if I am facing or think I may be facing an emergency situation that could result in harm to me or to another person I am not to seek an ePST session; instead, I agree to seek care immediately through my own local health care practitioner or at the nearest hospital emergency department or by calling 911.
- These are the names and phone numbers of my local emergency contacts (including local physician, crisis hotline, trusted family, friend, or adviser):

1. Name: _____ Phone Number:_____
2. Name: _____ Phone Number:_____
3. Name: _____ Phone Number:_____

Final Agreement:

- I have read this document carefully and fully understand the benefits and risks.
- I have had the opportunity to ask any questions I have and have received satisfactory answers.
- With this knowledge, I voluntarily consent to participate in ePST, including but not limited to any care, treatment, and services deemed necessary and advisable, under the terms described herein.

<u>Confirmation of Agreement:</u>

Client printed name:_____

eSignature of client:_____

Date: _____