Break Free
CENTER FOR WELLNESS, LLC

Sharron Riley-Seymour
642 Hilliard Street, Suite 1212, Manchester, CT 06042 ♦ 860-327-5790
Sharron@BreakFreeCenter.com

TELEMEDICINE/TELEHEALTH INFORMED CONSENT

I _____ [name of patient] hereby consent to engaging in telemedicine at Break Free Center for Wellness, LLC as part of my psychotherapy. I understand that "telemedicine" includes the practice of health care delivery, assessment, diagnosis, consultation, treatment, transfer of medical data, and psychoeducation using interactive audio, video, or data communications. I understand that, with my signed consent, telemedicine may also involve the communication of my mental health information, both orally and visually, to other health care practitioners located in Connecticut.

Technology: I understand that I will need to have a broadband Internet connection or a smart phone device with a good cellular connection.

Financial Obligations: Fees associated with telemedicine appointments are payable by credit or debit card as well as by check. If fees may be associated with my telemedicine services, I understand that I may also have the option of storing my credit/debit card information on file with Break Free Center for Wellness and that my card will be billed the same day as my scheduled telemedicine appointment. If my card is declined, Break Free Center for Wellness will charge me for any fees associated with the declined payment. (Client Initial: _____)

Clients using insurance: I am responsible for contacting my insurance company, if applicable, to determine what my out-of-pockets costs may be. I authorize insurance benefits to be paid directly to Break Free Center for Wellness, and that Break Free Center for Wellness may release any information to my insurance provider required for processing my claims. (Client Initial: _____)

Self-Pay clients: I am aware of the fees associated with telemedicine appointments and agree to pay at the time of my appointment. I understand that I am responsible for canceled telemedicine appointments in accordance with the Break Free Center for Wellness cancellation policy as documented by my signature on the Informed Consent. (Client Initial: _____)

Diagnostic Assessment	$150
Individual Therapy Session (45 minutes)	$80
Individual Therapy Session (60 minutes)	$110
Couples Session (45 minutes)	$95
Couples Session (60 minutes)	$125
Late Cancellation Fee	$75

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

Scheduling: I understand that scheduling is conducted through Break Free Center for Wellness and is based on their normal business hours. Telemedicine 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.

Video/Audio Recording: As a general practice Break Free Center for Wellness DOES NOT record Telemedicine sessions without prior permission.

Confidentiality: The laws that protect the confidentiality of my medical information also apply to telemedicine. 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. Break Free Center for Wellness's Telemedicine platform is HIPAA compliant to protect my privacy and confidentiality. This is further explained in the Informed Consent, which I have signed.

I understand that I have the following rights with respect to telemedicine:

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

I have read and understand the information provided above. I have discussed it with my counselor, 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

_____ _____

Provider's Signature Date

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TELEMEDICINE/TELEHEALTH EMERGENCY CONTACT FORM

In Case of an Emergency

If you have a mental health emergency, I encourage you not to wait for communication back from me, but do one or more of the following:

- Call Lifeline at (800) 273-8255 (National Crisis Line)
- Call 911
- Go to the emergency room of your choice

Emergency procedures specific to Telehealth services

There are additional procedures that we need to have in place specific to Telehealth services. These are for your safety in case of an emergency and are as follows:

You understand that if you are having suicidal or homicidal thoughts, experiencing psychotic symptoms, or in a crisis that we cannot solve remotely, I may determine that you need a higher level of care and Telehealth services are not appropriate. I require an Emergency Contact Person (ECP) who I may contact on your behalf in a life-threatening emergency only. Please enter this person's name and contact information below.

Either you or I will verify that your ECP is willing and able to go to your location in the event of an emergency. Additionally, if either you, your ECP, or I determine necessary, the ECP agrees take you to a hospital. Your signature at the end of this document indicates that you understand I will only contact this individual in the extreme circumstances stated above.

Please list your ECP here:

Name: _____

Phone: _____

Please inform me of the nearest hospital to your primary location that you prefer to go to in the event of a mental health emergency.

Please list this hospital and contact number here:

Hospital: _____

Phone: _____

Please inform me of the nearest police department to your primary location that you prefer to go to in the event of an emergency.

Please list this police department and contact number here:

Police Department: _____

Phone: _____