



1981 E Palmer-Wasilla Hwy, Suite 220, Wasilla, AK 99654
Phone: (907) 357-6513 | Fax: (907) 357-6514

PATIENT CONSENT TO ELECTRONIC COMMUNICATIONS

Any use of electronic communication must be pre-approved by Olive Tree Counseling, Inc. (aka, OTC), in agreement with the client, documented in writing, and kept in the client's records.

Telehealth & Online Services Terms and Conditions

I (the client) understand that this consent form must be filled in its entirety regardless of whether I wish to receive telehealth treatment. OTC is not liable for any claims and/or damages arising from the optional use of telehealth services. Telehealth services are *entirely voluntary* and will not influence the quality of care the client will receive from OTC, or condition treatment or payment on the optional use of telehealth services.

Alaska Telehealth/Telemedicine Definition, Alaska policy and regulations telemedicine references; Senate Bill 74 defines telehealth/telemedicine as the practice of health care delivery, evaluation, diagnosis, consultation, or treatment using the transfer of health care data through audio, visual, or data communications, performed over two or more locations between providers who are physically separated from the recipient or from each other, or between a provider and a recipient who are physically separated from each other.

*As a client receiving behavioral health services through online technologies, I (the client) understand that:

1. The interactive technologies used in tele-behavioral health incorporate network and software security protocols to protect the confidentiality of client information transmitted via any electronic channel. These protocols include measures to safeguard data and protect against intentional or unintentional corruption.
2. This service is provided by technology and may not involve direct, face-to-face communication. There are benefits and limitations to this service, such as the following:
 - a. Electronic systems used will incorporate network and software security protocols to protect the privacy and security of health information and imaging data and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption.
 - b. There are risks in 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.
 - c. In emergencies, disruption of services, or for routine or administrative reasons, it may be necessary to communicate by other means, i.e., through the cell phone number provided by the client.
 - d. In the event of disruption of services, the client must attempt to re-establish service at least twice before attempts to communicate via cell phone.
3. The client will need access to, and familiarity with, the appropriate technology to participate in the service provided.

4. The exchange of information will not be direct, and any paperwork exchanged will likely be provided through electronic means or through postal delivery.
5. During my (client) tele-behavioral health consultation, details of my medical history and personal health information may be discussed with myself or other behavioral health care professionals using interactive video, audio, or another telecommunications technology.
6. If a need for direct, in-person services arises, it is my responsibility to contact my practitioner or practitioners in my area, such as another provider in my behavioral practitioner's office, or secure an appointment with my primary care physician if my behavioral practitioner is unavailable. I understand that an opening may not be immediately available in other offices.
7. My practitioner and I will regularly reassess the appropriateness of continuing the online services agreed upon, and we will modify the treatment as needed.
8. It is my responsibility to maintain privacy on my end of communication. However, I understand that insurance companies, those authorized by me (the client), and those permitted by law may also have access to records or communications.
9. I may decline or discontinue any tele-behavioral health services at any time without jeopardizing my access to future care, services, and benefits.
10. Records of my communications and sessions will be stored in the same secure manner that face-to-face records are stored.
11. The laws and professional standards that apply to in-person behavioral services also apply to telehealth services. This document does not replace other agreements, contracts, or documentation of informed consent.
12. As the client, I understand the security of online communications is a two-way responsibility. My therapist will keep my communications private and secure on my therapist's end. However, it is *also my responsibility* to keep online communications private and secure on my end.

**Please list an example of how you (the client) will ensure all online communications will be kept private and directed only between you and your mental health provider or other authorized individuals (e.g.: I will keep my door locked and wear a headset. I will not let unauthorized individuals check my phone or email messages.)*

I (the client) will ensure privacy by:

E.g.: _____

Online Communications Preference

***If I (the client) authorize email, text, and other online communications, I understand that:**

1. Remote and online communication be misdirected to or intercepted and disclosed by unintended third parties and, therefore, may not be a confidential medium of communication.
2. Patients who have concerns should consider using another mode of communication.
3. Patients understand and agree that email and text transmission is being used for the convenience of the

4. Patients, notably those patients who have multi-user devices and/or accounts, are responsible for maintaining the confidentiality and security of their own devices and/or accounts. OTC is not responsible for information breaches on the end of patients' personal devices and/or accounts.
5. Regardless of whether the patient wishes to communicate with OTC via email, it is recommended that patients provide a working and up-to-date email address. Protected information will not be discussed via email without first being authorized by the patient (Please check your Junk mail inbox periodically).

☐ No, I do NOT authorize any online communications with OTC.

(Signature required regardless of opt-in/opt-out online communications status)



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ELECTRONIC COMMUNICATIONS: Text-To-Pay Authorization

*** IF YOU DO NOT WISH TO SIGN UP FOR TEXT-TO-PAY, PLEASE DISREGARD THIS PAGE ***

To always stay up to date with payments, OTC offers an optional **Text-To-Pay** service as a courtesy to the client. OTC utilizes this service through the online platform, *Office Ally*, powered via *STRIPE*, and is certified HIPAA compliant. However, as outlined above, texting is *fundamentally* not a secure method of communication and is only used at the clients' convenience and discretion.

If I (the client) sign up for **Text-To-Pay**, I acknowledge and understand the following agreement (please initial):

_____ I understand that texting is NOT a secure form of communication and the inherent risks associated, and
Initials I agree that OTC will not be held responsible for information breaches on my end.

_____ I understand the use of **Text-To-Pay** is completely optional and is only offered for my own personal
Initials convenience, and it does not affect the price or quality of the service I receive.

_____ I understand that I may opt-out of **Text-To-Pay** at any time with no penalty by contacting OTC via phone,
Initials email, letter, or verbally.

_____ I understand that OTC will only text the number to which I have already given authorization outlined in the
Initials CONSENT TO ELECTRONIC COMMUNICATIONS form that has been provided to me.

*Please Note: **Text-To-Pay** links do not expire even if the payment has already been made.*

*Please check the date before making payments via previously received **Text-To-Pay** links.*

My signature below shows that I wish to enroll in **Text-To-Pay**, and that I understand and agree with the above statements.

_____	_____	_____
Printed name of Client	Signature of Client	Date

_____	_____	_____
Signature of parent or guardian if applicable	Relationship to client (if necessary)	Date

____Holly Hoff, LPC ____Brittney Punt, LCSW ____Ken Brewington, LPC ____Keri Chandler, LPC ____Misti Musgrave, LCSW

_____	_____	_____
Printed name of Staff	Signature of Staff	Date