Open Arm
Mental Health

NORTHWEST OPEN ARM MENTAL HEALTH

VIRTUAL TELEHEALTH CONSENT AND HIPAA PRIVACY ACKNOWLEDGMENT

Patient Information

Patient Full Name: _____ Date of Birth: _____

Address: _____

Telephone: _____ Email: _____

Emergency Contact: _____ Phone: _____

1. Purpose of Telehealth Services

I understand that Northwest Open Arm Mental Health provides healthcare services through telehealth technology, allowing adult patients (18 and older) to receive psychiatric and mental health services remotely through secure audio and video communication. Services may include initial psychiatric evaluations, medication management, ADHD/depression/anxiety/bipolar and other condition management, medication monitoring, follow-up appointments, and treatment planning.

2. Nature of Telehealth Services

Telehealth involves communication with my healthcare provider through electronic technology rather than an in-person office visit. I acknowledge that telehealth requires an appropriate device and internet connection, I should participate from a private and safe location, my provider will make reasonable efforts to protect confidentiality, technical problems may interrupt appointments, and my provider may recommend an in-person evaluation when clinically necessary. If a visit is interrupted, my provider will contact me by the phone number I have provided.

3. Patient Identity and Location

My provider will confirm my identity at the start of each visit. I agree to state my current physical location (address) at the beginning of every telehealth appointment, and I understand that my provider may only be able to treat me while I am physically located in a state where the provider is licensed. If I am outside Minnesota, I will tell my provider before the visit begins, and the visit may need to be rescheduled.

4. HIPAA Privacy and Confidentiality

Northwest Open Arm Mental Health is committed to protecting personal health information in accordance with HIPAA, applicable federal and state privacy laws, and the clinic's Notice of Privacy Practices. Protected health information may include psychiatric evaluations and diagnoses, medication and treatment records, medical and psychiatric history, personal identifying information, appointment and billing information, and information communicated during telehealth sessions. Information will only be used or disclosed as permitted or required by applicable law.

5. Privacy During Virtual Appointments

I agree to participate from a private location whenever possible, use a password-protected device and secure internet connection, avoid participating in public areas, inform my provider if another person is present, and avoid recording or distributing telehealth sessions without prior written authorization. The clinic does not record telehealth sessions unless I and my provider agree in advance. The clinic will take reasonable steps to protect privacy but cannot guarantee the security of my personal device, internet connection, or surroundings.

6. Telehealth Technology and Third-Party Platforms

Northwest Open Arm Mental Health may use secure electronic health record systems and telehealth platforms, including Doxy.me or other approved platforms. Technology vendors may process limited information as necessary to provide services. Appropriate vendor agreements and safeguards will be used when required by HIPAA. I should not share appointment links or access credentials with unauthorized individuals.

7. Limitations and Risks of Telehealth

Telehealth has certain limitations, including technical interruptions, difficulty performing certain physical examinations, limitations in observing certain clinical symptoms, potential privacy risks associated with electronic communication, and the possibility that telehealth may not be appropriate for every condition. Some medications, including controlled substances, may be subject to federal or state rules that require an in-person evaluation or limit what can be prescribed by telehealth, and those rules may change. My provider may recommend an in-person appointment, additional assessment, emergency evaluation, or referral when clinically indicated.

8. Emergency and Crisis Management

Telehealth is not an emergency service. If I experience a psychiatric or medical emergency, I agree to call 911 or go to the nearest emergency department, call or text 988 for mental health crisis support when appropriate, notify my provider of significant safety concerns when possible, and provide an accurate emergency contact when requested. My provider may contact emergency services and my emergency contact if there is a serious and imminent risk to my safety or the safety of others.

9. Patient Rights and Responsibilities

I have the right to ask questions about telehealth, receive information about risks and benefits, decline or withdraw consent at any time, request in-person services when available and clinically appropriate, receive information about how my health information is used, request access to my records, and receive a copy of the Notice of Privacy Practices. Declining telehealth will not eliminate my right to discuss other appropriate treatment options.

10. Billing and Insurance

Telehealth services may be billed to my insurance provider or directly to me, depending on my coverage and the services provided. I acknowledge that I am responsible for applicable copayments, deductibles, coinsurance, and other financial obligations, as described in the Financial Responsibility and Payment Consent Form.

11. Consent and Acknowledgment

By signing below, I acknowledge that I have read and understand this form, have had an opportunity to ask questions, understand the benefits, limitations and potential risks of telehealth, understand that my protected health information will be handled in accordance with applicable privacy laws, voluntarily consent to receive psychiatric and mental health services through telehealth, and understand that I may withdraw my telehealth consent at any time.

☐ I have received or been offered a copy of the clinic's Notice of Privacy Practices.

Patient Signature

Patient Name: _____ Date: _____ Time: _____

Patient Signature: _____

Legal Representative (only if the patient has a court-appointed guardian or conservator)

Name: _____ Relationship / authority: _____

Signature: _____ Date: _____

Healthcare Provider Acknowledgment

Provider Name: _____ Credentials: _____

Provider Signature: _____ Date: _____

This form supplements the clinic's Notice of Privacy Practices and does not replace any separate HIPAA authorization required for specific disclosures of protected health information.