DAVIS BEHAVIORAL HEALTH
Community · Commitment · Change

Policies & Procedures

Telehealth

Section: Clinical Policies

Pages: 2

Subject: Telehealth

Effective Date: January 2020

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POLICY

PURPOSE:

Telehealth provides patients with access to behavioral and psychiatric health care via real-time phone and video communication.

POLICY:

Clients in need of behavioral healthcare as determined by their provider, will be referred to telehealth services provided at the affiliated site such as Doxy, Insight or a service offered by the Utah Department of Human Services.

PROCEDURE:

Providers will use their clinical judgment in selecting patients for the telehealth service. Clients who would otherwise be referred to an in-office may request a telehealth appointment with their provider and are welcome to utilize the telehealth service. Davis Behavioral Health administration may determine when telehealth services should be required of clients and providers. These reasons may include what administration feels is in the best interest of its employees' and clients' health and safety.

Clients who do not have insurance coverage for telehealth services can be referred to the service if they agree to pay for the service out-of-pocket. DBH will work with insurance providers to receive authorization for telehealth services if possible.

If the provider determines that one of his or her client could benefit from telehealth services, the provider will:

1) Discuss the service with the client or legal guardian and obtain their consent.
2) Client must have the necessary technology (phone, computer, bandwidth) in order to receive telehealth services
3) Clients must complete the required authorizations for telehealth services at intake. This includes the requirement to pay any required co-payments.
   If at any point the provider determines that it's necessary to see the client face to face, the provider may discontinue telehealth services.
4) If at any point the provider determines that it's necessary to see the client face to face, the provider may discontinue telehealth services.

Telehealth Consent Form

1. I authorize Davis Behavioral Health to allow me/the patient to participate in a telehealth (videoconferencing) service.
2. All services may be offered via telehealth unless direct contact is required (e.g., injections, urinary drug screens, residential treatment, etc.).
3. I understand that this service is not the same as an in-person visit, because I/the patient will not be in the same room as the behavioral health provider performing the service.
4. My/the patient's therapist has fully explained to me the nature and purpose of the videoconferencing technology as well as possible alternatives to the proposed sessions, including visits with a therapist in-person. I have been given an opportunity to ask questions, and all of my questions have been answered fully and satisfactorily.
5. I understand that there may be technical difficulties associated with using this form of treatment. I am aware that either my/the patient's therapist or I can discontinue the telehealth service if we believe that the videoconferencing connections are not adequate for the situation.
6. I agree to permit my/the patient's healthcare information to be shared with other individuals for the purpose of scheduling and billing.
7. It is the responsibility of the telehealth provider to conclude the service upon termination of the videoconference connection.
8. I/the patient understand(s) that my/the patient's insurance will be billed by Davis Behavioral Health and that I/the patient will be responsible to pay any insurance copay at the time of the appointment by entering my credit card number. I further consent to allow Davis Behavioral Health to safely and securely store my credit card number for ongoing copayments.
9. My/the patient's consent to participate in this telehealth service shall remain in effect for the duration of the services or until I revoke my consent in writing.
10. I confirm that I have read and fully understand the information above and have been given a copy of the *Telehealth: What to Expect Form*. I have crossed out any paragraphs or words above which do not pertain to me.

Patient/Relative/Guardian Signature*	Print Name
Relationship to Patient (if required)	Date
Provider's Signature	Date

I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives to (including no treatment) the proposed procedure, have offered to answer any questions and have fully answered all such questions. I believe that the patient/relative/guardian fully understands what I have explained and answered.