Information, Authorization and Consent to Telehealth

Patient information

Name: _____

Home address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ Email: _____

Group information

Name: _____

Type of group (choose one): ☐ Open ☐ Closed

Attendance requirements (please specify): _____

This document verifies your consent to participate in distance-oriented behavioral health services, otherwise known as telehealth, at the Torrance Memorial Medical Center Cancer Resource Center. Telehealth is the way in which we deliver counseling and group services through technology-assisted media, such as telephone (landline and mobile devices), internet, tablet, desktop systems or other electronic means using appropriate encryption for electronic health services. Sessions will take place over Zoom, which is a HIPPA-compliant telehealth platform. This document will also inform you about confidentiality, emergencies and several other expectations regarding details for support groups at the Cancer Resource Center.

What to expect

The support groups at the Cancer Resource Center are intended to offer a safe space for participants to process feelings and experiences related to a cancer diagnosis.

The facilitator(s)

The facilitator should maintain a professional relationship with the participants at all times. Any other relationship with a participant may result in a "dual relationship" and may affect the goals of the session. The facilitator is not always available in between sessions. You may email or call the facilitator with any non-urgent matters, and they will return your message the next business day. For urgent mental health concerns, please refer to the "In case of an emergency" section below.

Group membership

Participation is vital to the flow of the group. If there is a topic, however, that you would not wish to comment on, please know that you are able to pass. It is helpful for participants to have their video on during sessions. This allows members to connect and support each other more authentically and for the facilitator to identify important non-verbal cues. It is expected that all participants will maintain respect for one another. Please note – participants are in different stages of treatment and may have a different diagnosis than your own. Only supportive comments are welcome. The facilitator has the right to terminate a participant's membership in group if it is determined that they need a higher level of care or if they are disruptive to group.

Limitations of telehealth

While telehealth can be valuable when patients are not able to come in person for counseling or groups, there are limitations to this form of treatment. Please be aware that there is a risk of misunderstanding each other without in-person non-verbal cues. There may be disruptions caused by technical issues, which may affect the flow of group. The Cancer Resource Center facilitator can discontinue the telehealth session if the videoconferencing connection is not adequate to perform the session.

Confidentiality and privacy agreement

In order to respect each other's privacy, you agree not to disclose what is shared in the group to anyone who does not belong in the group. It is expected that participants will find a quiet and private space for group and individual sessions. No one other than the participant is able to be present during the session, unless previously discussed with the facilitator. In order to respect each other's time commitment to the group, it is understood that accepting outside phone calls, texts, emails or browsing the internet during group sessions is not permitted. Although every effort will be made to keep group members' identities confidential, there is no guarantee. We are trusting that everyone will do their part in maintaining group privacy. Video or audio recording or taking photographs of the group are not permitted during group; any violation will result in the participant's removal from the group.

While the information disclosed during the group is confidential, there are both mandatory and permissive exceptions to confidentiality, including child, elder and dependent adult abuse; threats of harm to self or others; or if court-ordered. Only information that is deemed a safety risk upon assessment by a licensed mental health professional will be revealed directly to the parent/adult guardian or authorities as needed.

Fees

Support groups at the Cancer Resource Center at Torrance Memorial Medical Center are free of charge to the group member.

In case of an emergency

If you have a mental health emergency, you are encouraged not to wait for communication back from your facilitator, but will do one of the following:

- Call the National Crisis Line (open 24/7): 800-273-8255
- Call the Los Angeles County Department of Mental Health Help Line (open 24/7): 800-854-7771
- Text **LA** to the Crisis Text Line: 741741
- Call 911
- Go to the nearest emergency room

If I am thinking of hurting myself or anyone else, or in a crisis that we cannot solve remotely, the facilitator may determine I need a higher level of care and telehealth services may not be appropriate. The Torrance Memorial Medical Center Cancer Resource Center requires an emergency contact person who your facilitator may contact on your behalf in a life-threatening emergency only. Please enter this information below:

Emergency contact person: _____

Relationship: _____

Phone number: _____

By signing this consent, I am consenting to participate in telehealth group and/or individual sessions and I understand my anonymity cannot be guaranteed and accept all risks associated with participating in a group session including possible re-disclosure of my private health information by another member. **I hold Torrance Memorial Medical Center, its employees and officers harmless from liability arising from telehealth group sessions.** I indicate my compliance with the above-stated expectations. I reserve the right to revoke my consent, in writing, at any time. I may specify the date, event or condition on which this consent expires. If none is stated, and if no prior notice of revocation is received, this consent will expire one year after the date it was initiated. Please print, date and sign your name below indicating that you have read and understand the contents of this Consent to Telehealth form, agree to these policies, and are authorizing your facilitator to use telehealth methods discussed.

Patient name (please print): _____ Date: _____

Patient signature: _____

Your facilitator's signature below indicates they have discussed this form with you and have answered any questions you have regarding this information.

Facilitator name (print): _____ License #: _____ Date: _____

Cancer Resource Center facilitator signature: _____