Bergen's PROMISE
Healthy Families, Safe at Home

3 University Plaza, Suite 300
Hackensack, NJ 07601
Phone: 201-712-1170
Fax: 201-712-0391
www.bergenspromise.org

GUIDELINES FOR SERVICE DELIVERY VIA TELEHEALTH
HIPAA Form 24

Youth Name: _____ CYBER ID:_____

BERGEN'S PROMISE care management services are intended to be provided in-person, in the community, for true fidelity to the Wraparound model of care and optimum effectiveness of strategy provision. However, there are exceptional situations where telehealth may be utilized due to health and safety concerns.

1. I hereby AGREE to the use of telehealth to facilitate service delivery when conditions do not allow for in-person service delivery as it could pose a direct health and safety concern, per State and federal guidelines.
2. I understand that BERGEN'S PROMISE will seek my voice and choice based on my needs/preferences for communication with my care manager in the beginning of every month to guide service delivery for the month.
3. I understand that there will be a safety screening completed prior to every in-person meeting that is scheduled to ensure there are health and safety concerns throughout the course of working with BERGEN'S PROMISE.
4. I understand that if there are confirmed health and safety concerns, I have the option request an alternative setting for meeting that resolves health/safety concerns (if applicable), to agree to conduct the meeting via telehealth or may choose to reschedule in-person meeting when the safety concerns are no longer present.
5. I understand that BERGEN'S PROMISE will communicate with me via a HIPAA compliant online videoconferencing telehealth platform. I understand there are potential risks in using this technology including interruptions and technical difficulties.
6. I understand that BERGEN'S PROMISE or I can discontinue a telehealth consult/visit if videoconferencing connections are not adequate and that we will resume contact via telephone.
7. I understand that my appointment information may be shared with other team members as is usual and customary with in-person sessions for the sole purpose of scheduling, billing, and collaboration.
8. I have had the opportunity to ask questions of my Care Manager regarding the use of telehealth, including any technology/resource challenges. My questions have been answered and the risks, benefits and any practical alternatives were discussed in a language in which I understand.
9. I understand that by using telehealth I agree not to either video or audio record the content of any part of the session under any circumstances.
10. I agree to the stipulation that no one is to be present during the session that is not specifically designated to be there for the visit or meeting. If we believe that someone is present in the room or can overhear the conversation, the session will be ended immediately.

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11. I agree to remain in a private well-lit space and to be dressed in an appropriate manner throughout the session.
12. The laws that protect confidentiality of any medical information also apply to online meetings and psychotherapy.

By signing this form, I certify:

• That I have read or had this form read and/or explained to me.

• That I fully understand its contents including the risks and benefits associated with the use of this tool.

• That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

• That I have provided my Care Manager that I am willing to use this method of service delivery when needed.

AUTHORIZED SIGNATURES

_____ _____
Signature of Parent / Legal Guardian/Youth 18+ Date

_____
Please Print Name

_____ _____
Signature of Youth (age 14 and over) Date

_____
Please Print Name

or

Reason Youth Could Not Sign (if age 18 or over): _____