Convergent Mental Health and Wellness, LLC

213 Old Padonia Rd, Cockeysville, MD 21030

443-840-8994

Telemedicine Safety Plan

Instructions: To receive telemedicine services at our practice, all questions on this form must be answered. If you move, you are responsible for updating your address with our practice and filling out a new form. If you are in a different location from what is listed below or your phone number changes, you are responsible for informing your provider at each session. For anyone to be present in your session, your provider must agree that it is clinically appropriate and there must be a signed release on file prior to the session. It is strongly recommended that children are not present for your session. If at any time these policies or your conditions of informed consent are not followed, your session will be ended, and you will be charged a fee in the amount of our private pay rate.

1. What address will you be located at during your telehealth session?

Address: __________

If meeting in multiple locations list a second option:

2nd Address: __________

2. What is the best number to reach you if we lose our connection?

Phone number: __________

3. Do you have a reliable connection to internet / Wi-Fi? ☐ Yes ☐ No

4. Do you have access to a private location to meet with your provider? ☐ Yes ☐ No
Private is defined as the ability to meet via teleconference with video and audio without any other person including children in the room.

5. Do you have any firearms or weapons in the home: ☐ Yes ☐ No

6. Is anyone typically present at your location when you are in session with your provider? ☐ Yes ☐ No

7. Do you feel safe in your home? Are there any safety concerns your provider should be aware of (including domestic violence, animals, building infrastructure, etc.)? ☐ Yes ☐ No

8. Emergency Contact:

Name: __________ Phone Number: __________

Email: __________

**By signing this form, I agree to, and I understand the following: I agree to allow the PACE Behavioral Health to call the above emergency contact. I agree to inform my provider at each session if I am located at a location that is not listed on this form, which must be in Maryland. I understand that I must fill out all sections of this form or I cannot engage in telemedicine at this practice. I understand, this form does not guarantee that I may engage in telemedicine and that some patients do not meet criteria for telemedicine. I also understand that certain sessions per discretion of my provider may require a face-to-face meeting in addition to a once-a-year mandatory meeting. I acknowledge that my typed name below is equivalent to a written signature.*

____________________ ____________________

Client / Guardian Name & Signature **Today's Date (MM/DD/YYYY)**