** CONSENT FORM for PARTICIPATION**

**in the ONLINE MBCT GROUP**

Only group participants who have submitted a signed online consent form outlining risks of working digitally will be allowed to participate in the group.

**This Consent form serves to inform you of the MBCT group guidelines. Your signature is requested as an acknowledgement of these guidelines and as an agreement to adhere to the guidelines in order to maintain a safe group experience and to protect all participants’ confidentiality. Because this MBCT group is online, there are particular expectations and regulations that also need to be reviewed and adhered to for the safety and confidentiality of the group. If there are any particular concerns you have regarding group safety and confidentiality after reading this document, I request you let me know during our first group meeting to review with the group.**

MBCT group is designed for individuals who are struggling or have struggled in the past with depression and/or anxiety and would like to enhance their coping skills to avoid relapse of these symptoms. If you are interested in participating in the MBCT group, you must first complete a screening by Dr. Sidney Edsall, the group facilitator, to confirm if MBCT is an appropriate treatment in consideration of your symptoms.

Because this MBCT group is located in a virtual online space, and group participants and group facilitators are not physically in the same location. Often times we may not even be in the same city. It is therefore requested that all group participants provide me, the group facilitator, with a local emergency contact person prior to starting the MBCT course. You can consider various options as your emergency contact, such as friend and/or loved one in your support network, a local clergy person, or perhaps even a nearby police station location if you live in a more remote location. Emergency contacts will only be contacted if there is a particular safety concern or emergency that needs to be addressed. More specifically, if there is any concern regarding harm to you or to someone else, I have an obligation to take action and will contact your provided emergency contact person.

In addition, this MBCT group may challenge your ideas about how to effectively manage depression and anxiety. Although it is not the intent of the group, it may at times be triggering, as we consider new ways to approach your thoughts and feelings. Because of this, and because the group format does not include much individual time to process any triggering events or experiences, it is an expectation that all group participants have a local behavioral health provider (either a psychiatrist and/or therapist) who can be available during the 8-week span of the MBCT group. Participants will only be allowed to participate in the group if they are able to provide the contact information of this local behavioral health provider. If I am your provider, then please acknowledge this on your “Local Behavioral Health Provider Contact” section of your Contact Form. I may contact your Behavioral Health provider in order to review your psychiatric history and confirm MBCT is an appropriate treatment for your symptoms at this time. For example, individuals who are actively using recreational drugs and/or alcohol are not generally considered appropriate for MBCT group participation and are advised to focus their care on substance use concerns first. Also, individuals experiencing psychotic symptoms are generally advised to use other treatments apart from MBCT group. There may be other considerations that need to be taken into account when considering MBCT participation, and will be evaluated on an individual basis.

All participants’ health history, contact information for participants, and associated contacts remains confidential. This data remains stored in a HIPPA-protected and secured healthcare record.

In consideration of the virtual online space of the group, it is requested that all participants keep their video “ON” while in attendance of the group. For safety reasons, it is important the group facilitator can see you throughout the entirety of the group. And, for community building reasons, it is important for you to see everyone in the group and for all other group participants to see you as well.

**Please provide your initials next to each statement below to acknowledge you have read, understand, and agree to the guidelines outlined in each statement.**

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I agree to keep my video “ON” while in attendance of the group. Only under special circumstances, I may be granted permission by the group facilitator to turn the video off for the remainder of a group session due to technical difficulties or privacy concerns that cannot be otherwise avoided.

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 I agree that what goes on in the group, will stay in the group.

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 I will not share/make notes of the names of group participants.

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I will not make notes that include any personal or potentially identifying details discussed by participants.

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I will be located in a setting where my screen cannot be seen by others and I will wear headphones if my audio might be overheard.

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 I will not record or take screen captures of any group session and I will not copy, paste, or save any chat logs.

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If there is a serious confidentiality issue (e.g. another person can see my screen) I understand I will be removed from the session and will not log back in until the concern is resolved.

Please sign below, to acknowledge you have read this consent form in its entirety and agree with the requirements for group participation.

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**Signature Print Name Date**



Consent to Use Telemedicine

Patient’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ My Doctor’s Name: Sidney Edsall, MD\_\_\_\_\_\_\_

**CONSENT TO USE TELEMEDICINE**

I am physically located in California. At the beginning of each telemedicine session, I will help my doctor to complete a check-in to assess the suitability of using telemedicine services by verifying my full name, my current location, my readiness to proceed, and whether I am in a situation conducive to private, uninterrupted communication. By signing this consent, I understand and agree:

1. My doctor is located in and licensed by the State of California. My doctor may not be able to prescribe medications for me and/or may not be able to assist me in an emergency situation when I am located in any other state or country. If I require medication, I may contact my doctor. If I require emergency care, I may call 911 or proceed to the nearest hospital emergency room for help.
2. I submit to the exclusive jurisdiction of the California state superior courts and agree that any claim, lawsuit, or other legal proceeding arising out of or relating to the telemedicine services provided by my doctor and my doctor’s staff will be brought solely and exclusively in California state superior courts. I also agree that the interpretation of this consent will be exclusively governed by and construed in accordance with the laws of California.
3. My doctor believes that telemedicine services are appropriate for my medical condition and that I would benefit from its use despite its risks and limitations. While I may expect anticipated benefits from the use of telemedicine, no specific results can be guaranteed or assured.
4. If my doctor believes at any time that another form of services (for example, a traditional in- person consultation) would be appropriate, my doctor may discontinue telemedicine services and schedule an in-person consultation with my doctor or refer me to a healthcare provider in my area who can provide such services.
5. I have the right to withdraw consent to the use of telemedicine services at any time and receive in-person healthcare services with my doctor.
6. I received an explanation of how the electronic communications technology will be used for the telemedicine services. I am comfortable with using electronic communications technology to communicate with my doctor and understand there are limitations to the technology which may require an in-person consultation.
7. I agree to have the necessary computer, equipment and internet access for my telemedicine communications. I also agree to arrange for a location with sufficient lighting and privacy and is free from distractions and intrusions during my telemedicine communications.

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1. The laws that protect privacy and the confidentiality of my medical information also apply to telemedicine. The medical information that is transmitted electronically by my doctor to me will be encrypted during transmission and will be stored only by my doctor or a service provider selected by my doctor. I understand the dissemination of any personally-identifiable images or information from the telemedicine communication to researchers or other healthcare providers will not occur except as required by federal or California state law.
2. I understand my risks of a privacy violation increase substantially when I enter information on a public access computer, use a computer that is on a shared network, allow a computer to “auto-remember” usernames and passwords, or use my work computer for personal communications. I also understand it is my responsibility to encrypt medical information I transmit electronically to my doctor and my failure to use technical safeguards, such as encryption, increases my risks of a privacy violation.
3. [I agree to be videotaped and recorded during the telemedicine services. I understand the resulting images and audio will become part of my medical record.] OR [No part of the encounter will be recorded without my written consent.]
4. I have the right to access my medical information and obtain copies of my medical records in accordance with California law.
5. I understand that the telemedicine services provided to me will be billed to my health insurance company and that I will be billed for any patient responsibility as per my insurance.

I read and understand the information provided in this Consent to Use of Telemedicine. I discussed any questions I had with my doctor and all of my questions were answered to my satisfaction.

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Revised 7/2019