Psychiatric Wellness Center

Telebehavioral Health Safety Plan

Instructions: In order to receive telebehavioral health 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, 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 our private pay rate.

1. What address will you be located in during your telehealth session? Must be located in New Hampshire or Massachusetts.
   Street Address: **Apt #**

   City: **State:** **Zip Code:**

   If meeting in multiple locations, list a second location.
   Street Address: **Apt #**

   City: **State:** **Zip Code:**

2. Do you have a reliable connection to wifi: **YES** **NO** (If no, please call our office.)
3. What is the best number to reach you if we lose our connection? Phone number:_____
4. Do you have access to a private location to meet with your provider? Private is defined as the ability to meet via teleconference with video and audio without any other person including children in the room. **YES** **NO** (If no, please call our office.)
5. Please provide the local police department and their non emergency number below: Police Department:_____ Phone number:_____
6. Do you have any firearms or weapons in the home: **YES** **NO**
7. Is anyone typically present at your location when you are in session with your provider? **YES** **NO**
   If yes, please list:
8. Do you feel safe in your home? (are there any safety concerns your provider should be aware of including: domestic violence, animals, building infrastructure): **YES** **NO** (If yes, please call our office.)

9. We require an emergency contact to call if your provider can not get in touch with you to ensure your safety. Please list their contact information and complete and submit a release form.

   Name: _____ Relationship to you: _____
   Phone number: _____ Do they live with you in your home: **YES NO**

By signing this form, I agree to and I understand the following: I agree to allow the Psychiatric Wellness Center 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 New Hampshire or Massachusetts. I understand that I must fill out all sections of this form or I can not engage in telebehavioral health at this practice. I understand, this form does not guarantee that I may engage in telebehavioral health services and that some patients do not meet criteria for telebehavioral health services. I also understand that certain sessions per discretion of my provider require a face to face meeting in addition to a once a year mandatory face to face meeting.

Printed Name: _____ Date:_____
Signature:_____ Date: _____

Parent/Legal Guardian
Printed Name:_____ Date: _____
Signature:_____Date: _____