Interface EAP

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Phone (713) 781-3364 (800) 324-4327
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E-Counseling Attestation Form

Provider Name:	**TIN**	**Degree/License**
Mailing Address:		
Email Address:	Phone#	

Interface defines E-Counseling as a subset of telemedicine or telehealth. Telehealth is the use of a variety of communication technologies between health care practitioners and the service users for the purpose of diagnosis, treatment, consultation, education and other behavioral health services provided remotely via technology assisted media such as telephone, computer or internet.

Are you currently a telehealth provider?

☐ Yes
☐ No

Telehealth Requirements

Select all that is applicable, to indicate compliance and understanding of requirement

☐ Obtain client written consent to participation in telehealth services
☐ I have written and published protocols to ensure telehealth services meet the requirements of state and federal laws and established client's standards
☐ Compliance of record keeping for telehealth services is provided to clients.
☐ Professional liability insurance is in place for required limits per occurrence and aggregate and includes services performed via telehealth in the coverage territory where the services occurs.

Identify what secure technology platform you currently use

Telehealth Platform _____.

*All telehealth sessions must be conducted through secure and HIPAA compliant technology.

Note: Skype and Face Time are not considered secure HIPAA compliant technology

Please indicate what states you are actively licensed:

_____ _____ _____

_____ _____ _____

I certify that the information provided herein, meets the criteria for E-Counseling services provided via my credentialed practice. I have read and have full understanding of Interface Behavioral Health requirements for delivery of services, including telehealth services, for Interface. I understand it is my responsibility to comply with all Interface, state, and federal telehealth regulations and guidelines. I further understand that the information provided herein, represents full and truthful disclosures of the matters to which they pertain. I understand that omission or falsification of data may invalidate any agreements in place with Interface EAP.

I understand and agree that I, as an applicant, have the burden of providing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any doubt about such qualifications. I understand that Interface may verify all or any of the information contained herein.

Provider Name - printed
Provider Signature Date