OtterWell
Mental Health LLC
https://otterwellmentalhealth.com
Phone: 503-836-3152 • Fax: 503-836-3155 • info@otterwellmentalhealth.com
1336 NW Flanders Street #143 Portland, Oregon 97209

Emergency Contact Form for Telepsychology Services

There are additional plans we need to have in place, specific to telepsychology services. The purpose of this form is to manage your safety in case of an emergency and to understand your preferred communication methods if technology fails.

Emergency Plan:

You understand that if you are having suicidal or homicidal thoughts, experiencing psychotic symptoms, or in a crisis that cannot be solved remotely, your provider may determine that you need a higher level of care, and telepsychology services are not appropriate.

OtterWell Mental Health LLC requires an Emergency Contact Person (ECP) who your provider may contact on your behalf in a mental health or physical health emergency. Emergencies include:

- Situations where there is a threat to your life or safety or the life or safety of another person.
- Situations in which your provider cannot determine that you are safe, your provider has reason to believe you may be at risk, and they are unable to get in contact with you to make sure you are safe.

In the event that you do not cancel and do not show up to your telehealth appointment and do not respond to efforts to reach you, your provider may reach out to your Emergency Contact Person to verify that you are safe. In these uncertain times, it is especially important that you communicate with your provider so it is not incorrectly assumed that you are in crisis.

By signing this form, you agree that you will verify your ECP is willing and able to go to your location in the event of an emergency. Additionally, if either you, your ECP, or your provider decides it is necessary, the ECP agrees to take you to a hospital. Your signature at the end of this document indicates that you understand and give permission for your provider to contact this individual in the event of one of the emergencies listed above.

Please list your Emergency Contact Person (ECP) here.

Name:

Phone:

Relationship:

You agree to inform your provider of the address where you are at the beginning of every session.

Please list the primary address where you plan to engage in your telehealth sessions.

Address:

You agree to inform your provider of the hospital that you prefer to go to in the event of a mental health emergency.

Please list this hospital and contact number here:

Hospital:

Phone:

Please provide any additional emergency information or instructions not covered above.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Patient Name Date