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Informed Consent for TeleMental Health Services

This document covers your rights, risks and benefits associated with receiving TeleMental Health, our policies, and your authorization. Please read this document carefully, note any questions you would like to discuss, and sign.

TeleMental Health Defined:

TeleMental Health means the remote delivering of health care services via technology-assisted media. This includes a wide array of clinical services and various forms of technology. This technology includes, but is not limited to video, internet, a smartphone, tablet, PC desktop system or other electronic means. The best delivery method is a secure HIPPA compliant platform. We use 1) doxy.me and 2) Zoom. During the COVID-19 Pandemic, we can also use non-HIPPA compliant communications such as telephone, FaceTime, Google Hangouts...at both your discretion.

Limitations of TeleMental Health Therapy Services:

TeleMental Health may involve disadvantages and limitations that can interrupt the normal flow of personal interaction, such as a disruption to the service (e.g., video or audio drops). Primarily, there is a greater risk of misunderstanding one another when communication lacks visual or auditory cues. Additionally, the therapy office decreases the likelihood of interruptions. However, there are ways to minimize interruptions and maximize privacy and effectiveness. As the therapist, I will take every precaution to insure a technologically secure and environmentally private psychotherapy sessions. As the client, you are responsible for finding a private quiet location where the sessions may be conducted. We strongly suggest you only communicate through a device you know is safe and technologically secure (e.g., has a firewall, anti-virus software installed, password protected, not accessing the internet through public WIF, etc.).

In Case of Technology Failure:

During a TeleMental Health session we could encounter difficulties with hardware, software, equipment, and/or services supplied by a 3rd party, resulting in service interruptions. If something occurs to prevent or disrupt an appointment and the session cannot be completed, please contact your therapist promptly and we will do our best to troubleshoot the difficulty and continue with the session. In some cases, we may need to reschedule.

Insurance & Payment:

You are responsible for understanding and verifying your mental health and TeleMental Health benefits. During the COVID-19 pandemic, all insurances are allowing TeleMental Health, but please contact your insurance provider to verify coverage so you are informed of the duration of this change. Some insurances were already allowing TeleMental Health. Knowing this information could give you options beyond the COVID-19 Pandemic. For private pay clients, a credit card is required prior to providing TeleMental health therapy, for ease of billing. Please sign and return the Credit Card Payment Form giving your therapist permission to charge your card without you being physically present. Your credit card will be charged at the conclusion of each TeleMental health interaction.

Email:

Texting and emails are not considered TeleMental Health. Please know that our policy to utilize this means of communication is strictly for appointment confirmations. Please do not bring up any therapeutic content via email. We have a HIPPA compliant secure email for sending therapy related communication to you directly. It is easy to use but requires you to create a log-in and password to be able to open up any documents we might include in the email.

Social Media

Please do not communicate with us on any social media venues.

Cancellation Policy

In the event you are unable to keep either a TeleMental Health appointment, you must notify us at least 24 hours in advance. If such advance notice is not received, you will be financially responsible for the session you missed as insurance companies do not reimburse for missed sessions.

Emergency Management Plan

We will do our best to meet with you in the event of a crisis. In the event of an emergency it is imperative you are aware of the resources in your area. As a precaution, please identify two nearby emergency hospitals below. In addition, you will need to provide information for an emergency contact person. These all must be completed to participate in TeleMental Health.

1. Hospital Name and Location _____
Hospital Telephone Number: _____
2. Hospital Name and Location: _____
Hospital Telephone Number: _____

Emergency Contact Person: _____
Relationship _____ Telephone Number: _____

You may alternatively follow this plan:

1. Call Lifeline at (800) 273-8255 (National Crisis Line)
2. Call 911.
3. Go to the emergency room of your choice.

Informed Consent

I, the client, agree to the afore mentioned policies. I agree to take full responsibility for the security of any communications or treatment on my own computer or electronic device and in my own physical location. I understand I am solely responsible for maintaining the strict confidentiality of my user ID, password, and/or connectivity link. I shall not allow another person to use my user ID or connectivity link to access the services. I also understand that I am responsible for using this technology in a secure and private location so that others cannot hear my conversation. I understand that all written records pertaining to sessions are confidential and may not be revealed to anyone without my written permission, except where disclosure is required by law.

I voluntarily consent to treatment TeleMental Health and authorize Carter Counseling Center to provide such treatment. I understand that I may withdraw consent for such treatment at any time. By signing this Informed Consent, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

I consent to the use of the following forms of communication via technology:

- ___ Phone @ _____
- ___ Texting @ _____
- ___ Email @ _____
- ___ Fax @ _____
- ___ Document Sharing via secure email

Patient/Client Signature

Date

Parent, Guardian or Legal Representative (if minor or needed otherwise). Date