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Informed Consent for TeleMental Health Services

The following information is provided to clients who are seeking TeleMental health therapy. This document covers your rights, risks and benefits associated with receiving services, my 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. The technology includes but is not limited to, a telephone, video, internet, a smartphone, tablet, PC desktop system or other electronic means. The delivery method must be secured by two-way encryption to be considered secure. Synchronous (at the same time) secure video chatting is the preferred method of service delivery.

Limitations of TeleMental Health Therapy Services:

While TeleMental health offers several advantages such as convenience and flexibility. It is an alternative form of therapy or adjunct to therapy and thus may involve disadvantages and limitations. For example, there may be a disruption to the service (e.g., phone gets cut off or video drops). This can be frustrating and interrupt the normal flow of personal interaction. Primarily, there is a risk of misunderstanding one another when communication lacks visual or auditory cues. For example, if video quality is lacking for some reason, I might not see various details such as facial expressions. Or, if audio quality is lacking, I might not hear differences in your tone of voice that I could easily pick up if you were in my office.

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. Consider using a “do not disturb” sign/note on the door. The virtual sessions must be conducted on a WiFi connection for the best connection and to minimize disruption.

In Case of Technology Failure:

I understand that during a TeleMental health session we could encounter a technological failure. Difficulties with hardware, software, equipment, and/or services supplied by a 3rd party may result in service interruptions. If something occurs to prevent or disrupt any scheduled appointment due to technical complications and the session cannot be completed via online video conferencing, please call the therapist back at: **(678) 666-4717**. Please make sure you have a phone with you, and I have that phone number. We may also reschedule if there are problems with connectivity.

Structure and Cost of Sessions:

I offer face-to-face psychotherapy when appropriate and available. However, based on your ability to make in-person sessions and my availability, I may provide virtual psychotherapy if your treatment needs determine that TeleMental health services are appropriate for you. If appropriate, you may engage in either face-to-face sessions, TeleMental health, or both. We will discuss what is best for you. Please remember that your insurance company may or may not cover therapy via phone or video. We are both responsible for understanding your mental health benefits. Please contact your insurance provider to verify coverage via TeleMental health.

The structure and cost of TeleMental health sessions are exactly the same as face-to-face sessions described in the general “Authorization & Consent to Treatment” and “Insurance Agreement" forms. Texting and emails (other than just setting up appointments) are billed at my hourly rate for the time I spend reading and responding. For private pay clients, I require a credit card ahead of time for TeleMental health therapy for ease of billing. Please make sure you have signed the Credit Card Information Form, which was sent to you separately and indicates that I may charge your card without you being physically present. Your credit card will be charged at the conclusion of each TeleMental health interaction.

Email:

Email is not a secure means of communication and may compromise your confidentiality. However, I realize that many people prefer to email because it is a quick way to convey information. Nonetheless, please know that it is my policy to utilize this means of communication strictly for appointment confirmations. Please do not bring up any therapeutic content via email to prevent compromising your confidentiality. You also need to know that I am required to keep a copy or summary of all emails as part of your clinical record that address anything related to therapy.

I also strongly suggest that you only communicate through a device that you know is safe and technologically secure (e.g., has a firewall, anti-virus software installed, is password protected, not accessing the internet through a public wireless network, etc.). If you are in a crisis, please do not communicate this to me via email because I may not see it in a timely matter. Instead, please see below under "Emergency Management Plan.” Please use the TheraPortal to send secure communications and share documents.

Social Media - Facebook, Twitter, LinkedIn, Instagram, Pinterest, Etc:

Please refer to our Social Media Policy. Clinicians at Perimeter Therapy Associates are not able to "friend" clients on Facebook or other social media sites or connect on LinkedIn as this could compromise the confidentiality of clients. Our clinicians also do not Tweet with clients. Please refrain from contacting me using social media messaging systems such as Facebook Messenger or Twitter. These methods have insufficient security, and I do not watch them closely. I would not want to miss an important message from you.

Electronic Transfer of PHI and Credit Card Transactions:

I utilize KASA for billing and as the company that processes your credit card information. I may send the credit card-holder a text or an email receipt indicating that you used that credit card for my services, the date you used it, and the amount that was charged. This notification is usually set up two different ways - either upon your request at the time the card is run or automatically. Please know that it is your responsibility to know if you or the credit card-holder has the automatic receipt notification set up in order to maintain your confidentiality if you do not want a receipt sent via text or email. Additionally, please be aware that the transaction will appear on your credit card bill. You can send secure documents through the TheraPortal

including payment information. I will use this as the primary method of communication regarding payment and other personal health information related sharing.

Cancellation Policy:

In the event that you are unable to keep either a face-to-face appointment or a TeleMental health appointment, you must notify me at least 24 hours in advance. **If such advance notice is not received, you will be financially responsible for the session you missed. Please note that insurance companies do not reimburse for missed sessions.**

Emergency Management Plan:

In the event of an emergency, it is imperative you are aware of resources in your area. As a precaution, please identify two (2) 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 services.

1. Hospital Name and Location: Ridgeview Institute 3995 S Cobb Dr SE, Smyrna, GA 30080_____

Hospital Telephone Number:__770.434.4567_____

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 Georgia Crisis Line 1-800-715-4225
3. Call 911.
4. Go to the emergency room of your choice.

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 there will be no recording of any of the online session and that all information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without my written permission, except where disclosure is required by law.

Consent to Treatment:

I voluntarily agree to receive online therapy services for an assessment, continued care, treatment, or other services and authorize Perimeter Therapy Associates to provide such care, treatment, or services as are considered necessary and advisable. I understand and agree that I will participate in the planning of my care, treatment, or services and that I may withdraw consent for such care, treatment, or services that I receive through Perimeter Therapy Associates 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.

Please know that I have the utmost respect and positive regard for you and your wellbeing. I would never do or say anything intentionally to hurt you in any way, and I strongly encourage you to let me know if something I've done or said has upset you. I invite you to keep our communication open at all times to reduce any possible harm.

Please use technology with discretion. Only communicate limited information such as appointment request, cancellations, or estimated time of arrival.

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

___ Texting
___ Email
___ Fax
___ Document Sharing via TheraPortal
___ Recommendations to Websites or Apps

_____
Patient/Client Signature

_____
Parent, Guardian or Legal Representative Signature (if minor or needed otherwise)

_____
Date

My signature below indicates that I have discussed this form with you and have answered any questions you have regarding this information.

_____
Attending Psychotherapist