



Informed Consent for Telemental Health

The following information is provided to clients opting for telemental health therapy as part of their service delivery of mental health treatment provided by Perspectives Therapy Services. This document covers your rights, risks and benefits associated with receiving telehealth services, our policies, and your authorization. You are asked to initial after each section to indicate that you have read and understand the content. Please ask questions and get clarification if needed, prior to signing this document.

Telemental health defined:

Telemental health refers to mental health services that are delivered remotely, using technology-assisted media. The technology devices may include, but are 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. PTS utilizes a HIPAA secure platform called Doxy for live video-conferencing (referred to as “synchronous”) as our preferred method of telemental health delivery.

_____ *Client initials*

Limitations of Telemental Health Service Delivery

While Telemental health offers several advantages such as convenience and flexibility. It is an alternative form of therapy or adjunct to therapy, and thus involves some disadvantages and limitations worth noting.

Technology is not flawless and can come with interruptions to clear communication. For example, there may be a disruption to the service (e.g. the video drops or is “glitchy”). This can be frustrating and interrupt the normal flow of a personal interaction. The risk of misunderstanding one another when communication lacks clear visual or auditory cues that would be present in face-to-face interactions. For example, if video quality is lacking, your therapist might not see details such as facial expressions to be able to accurately interpret a reaction or emotional response. Or, if audio quality is lacking, your therapist may not hear differences in your tone of voice that they could easily pick up in you were in their physical office.

Additionally, the physical therapy office decreases the likelihood of disruptions to the session. However, together we will work to minimize these so that you will experience the intention of a therapy session to “hold space” for you and your thoughts and feelings. Our goal together will be to maximize privacy and achieve a high level of effectiveness through this, or another form of therapy service delivery we choose together. As the therapist, I will take every precaution to insure 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. Virtual sessions should be conducted using a secure (not public) wifi connection for the best results, to minimize disruption and maximize privacy.

_____ *Client initials*

In Case of Technology Failure

I understand that during a telemental health session, we could encounter a technological failure. Difficulties with hardware, software, equipment, wi-fi connectivity, 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 your therapist to continue/complete the session by phone. We may also mutually decide to reschedule if technology fails us.

_____ *Client initials*

Structure and Cost of Sessions

Face-to-face therapy in our physical clinic location is the primary means of service delivery through Perspectives Therapy Services. Sometimes, special circumstances warrant an alternative means of service delivery, such as telemental health, so that care is not interrupted (i.e. illness/health-related circumstances, inclement weather, travel out of the geographic area, etc.). Please be aware that your insurance company may or may not cover telemental health sessions. We strongly recommend that you contact your insurance provider to verify coverage via telemental health.

The structure and cost of telemental health sessions are the same as in-person sessions described in the general consent form that you initially sign with PTS. Texting and emails (other than just setting up appointments) are billed at an hourly rate for the time spent reading and responding. These out-of-session services are not billable to insurance. As standard at PTS, we require a credit card to remain on file for ease of billing and will charge the card at the beginning of each session for any balance due including copays or deductible amounts. You will need to sign a Credit Card Authorization to keep on file.

_____ *Client initials*

Email and Text Messaging

PTS uses the companies Enguard and iPlum as HIPAA secure technology communication systems when it comes to connecting via email or text. Although these systems have been chosen because they take extra precautions to protect privacy, email or text are not preferred methods of communication as they have the potential to compromise your confidentiality. Nonetheless, please know that it is our policy to utilize this means of communication strictly for appointment confirmations. Please do not bring up any therapeutic content via email or text to prevent compromising your confidentiality.

We 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, do not communicate this to your therapist via email or text as they may not see it in a timely manner. Instead, please see the "Emergency Management Plan" below.

_____ *Client initials*

Social Media

If you choose to follow Perspectives Therapy Services on social media, please do not reference our work together as it may compromise your confidentiality and blur the boundaries of our relationship. If this occurs, we may make the decision to block you from our social media sites as your confidentiality is a top priority for us. Please only follow our Facebook page if you are comfortable with the general public being aware of the fact that your name is attached to Perspectives Therapy Services, a known mental health practice. Please refrain from making contact with PTS using social media messaging systems such as Facebook Messenger. These methods have insufficient security, and we do not monitor them closely. Our social media presence has nothing to do with our mental health services (live or tele), and rather, is intended to be a general tool for communicating positive, inspiring, and validating mental health and wellness information (of a non-clinical nature) to the general public.

_____ *Client initials*

Cancellation Policy

Our cancellation policy is the same for in-person therapy or telemental health and is outlined in our general consent form that you initially sign with PTS. Unless a session is cancelled 24 hours in advance, you will be responsible to remit payment of \$75 for a missed therapy session. This is a strict policy with no exceptions. Please remember that if you are using insurance, charges cannot be submitted for missed sessions and you will be held responsible for the charges as specified above. The credit card on file will be automatically charged

for this fee when applicable. In cases of excessive absences, it will be your therapist's discretion to terminate services at PTS and refer your care elsewhere.

_____ **Client initials**

Emergency Management Plan

We are not available for emergency or crisis services, and advise that in these cases, you follow any part of this plan:

1. Reach out to your Emergency Contact Person for support, transportation or monitoring

Emergency Contact Person Name: _____

Relationship: _____ Phone number: _____

**This information must be completed to participate in telemental health services.*

2. Go to your local Community Mental Health agency
3. Go to your local emergency room/medical center/hospital
4. Call 911
5. Call Lifeline at (800) 273-8255 (National Crisis Line)

_____ **Client initials**

CONSENT TO TREATMENT

- 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 that 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 or archive of our electronic exchange 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.*

- I, voluntarily agree to participate in online mental health therapy services for assessment, continued care, treatment, or other services and authorize my therapist within Perspectives Therapy Services, LLC 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 PTS at any time. By signing this Informed Consent, I, the undersigned client, acknowledge that I have both read and understand 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.*

Client Printed Name

Date

Signature of Client or Parent, Guardian, Legal Representative
(if client is a minor)

Relationship to the Client