INTOWN
COUNSELING & WELLNESS

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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 and note any questions you would like to discuss.

Client's Rights

- You have the right to decide to end our psychotherapy work at any time without prejudice. If you wish, I will provide you with the names of other qualified therapists.
- You have the right to ask any questions about procedures used during therapy. If you wish, I will explain my usual method of psychotherapy practices with you.
- You have the right to refuse the use of any therapeutic technique. I will inform you if I intend to use any unusual procedures and explain any risks involved.
- You have the right to learn about alternative methods of treatment. I will discuss these with you during our work together.
- Telemental health services are not appropriate for all clients. Generally, those who are experiencing suicidal ideation or altered mental status are not appropriate. Should telemental health services not be a good fit for you, I will assist you in finding alternative options.

Benefits and Risks

Telemental health refers to psychotherapy services that occur via phone, email, or synchronous video conferencing. All of our interactions will fall under this term. When using technology there is always the risk of security issues, as well as technical issues (phone not charged, computer or software not working, etc.). You will develop an individualized plan for how best to address technical issues that may arise and will take steps to facilitate the security of interactions with your therapist. In addition to the identified risks, there are several benefits that come from using technology. For instance, it allows therapists to connect with people who may otherwise not be able to access services, there is an opportunity for more flexibility in scheduling, and convenience in being able to connect from a space of your choosing. In order to protect your confidentiality and to facilitate the security of your information as much as possible, here is a list of recommendations:

- Engage in sessions in a private location where you cannot be heard by others

- Use a private phone
- Do not record any sessions
- Password protect any technology you will be interacting with your therapist on
- Always log out or hang up once sessions are complete
- To avoid others knowing we have connected, your therapist will be contacting you from a blocked number.

Emergency Management Plan

Intown Counseling and Wellness does not provide emergency services. 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 need to be filled out to participate in telemental health services.

Hospital #1 Name:	
Hospital #1 Address:	
Hospital #1 Phone:	

Hospital #2 Name:	
Hospital #2 Address:	
Hospital #2 Phone:	

Emergency Contact Name:	
Emergency Contact Number:	

Contacting Your Therapist

Email is the main form of contact that will be used outside of the consultation and sessions. Please note that email is not secure, so communication should be limited to scheduling questions, providing resources, and supplying any applicable insurance information.

Payment for Services

- Payments for services are **only accepted via credit card**.
- Payments will need to be made **prior** to the start of session. For your convenience you may fill out the below credit card information so that it is on file:

Name on Card:	
Credit Card Number:	
Expiration Date:	
Security Code:	
Billing Zip Code:	

- If you need to cancel an appointment, please do so as early as possible. **Cancellations that are NOT within 12 hours of your confirmed consultation or session time are subject to a cancellation fee that is 50% of the session cost**.
- I practice as an out of network provider, therefore this form serves as an agreement the session fees will be paid in full at the time services are provided and each out of network claim will be handled by the policy holder.

Authorization for Treatment

I, _____, authorize evaluation and treatment from

_____. I acknowledge that I have may request a copy of this informed consent agreement. It is agreed that either of us may discontinue treatment at any time.

_____

Signature Date