**Lilac City Counseling, Inc.**

**Information and Informed Consent for Telemental Health Treatment**

**Tools and Technology of Telemental Health:**

* I understand that telemental health is live two-way audio and video electronic communications to enable therapists and clients to meet outside of the office setting.
* I understand that Lilac City Counseling’s therapists typically provide telemental health services using Doxy.Me

\* I understand that I will need access to internet service and either a smart phone, laptop, or tablet with speaker and video camera in order to engage in telemental health work with my therapist.

\* I understand that I will also need access to a phone in case of interruption of the telemental health session.

\* I understand that I will need to furnish my therapist with my email in order to transmit this Informed Consent document and also in order for my therapist to provide me with a link to our session on Doxy.me. I understand that Lilac City Counseling uses only mildly encrypted or unencrypted email technology and that unencrypted messages can be intercepted during transmission.

\* I understand that if I have any questions or concerns about the telemental health technology or process, I can address them directly to my therapist.

**Benefits of Telemental Health:**

* I understand that telemental health may enable me to receive services when I am unable to travel to my therapist’s office.
* I understand that telemental health may enable me to receive services in a fashion that is more physically safe or healthy for me.
* I understand that telemental health may enable me to receive services in a fashion that may be more convenient for me.

**Risks of Telemental Health:**

* I understand that telemental health services can be impacted by technical failures. Interruptions may disrupt services at important moments and my therapist may be unable to reach me quickly or using the most effective tools. Interruptions could be caused by the following:
* Internet connections or cloud services could cease working or become too unstable to use.
* Computer or smartphone hardware can have sudden failures or run out of power
* Local power services can go out.
* I understand that telemental health services have some increased risks to privacy. Although Doxy.Me is an encrypted platform, I understand that any internet based communication is not 100% guaranteed to be secure. I agree that Lilac City Counseling, Inc. will not be held responsible if any outside party gains access to my personal information by bypassing the security measures of the communication system.
* I understand that telemental health service may reduce my therapist’s ability to directly intervene in crises or emergencies.

**Privacy and Security:**

* I understand that this form is signed in addition to the Notice of Privacy Practices and Consent to Treatment and that all office policies and procedures apply to telemental health services.
* I understand that the laws that protect privacy and the confidentiality of client information also apply to telemental health, and that no information obtained in the use of telemental health that identifies me will be disclosed to other entities without my consent.
* I understand that my therapist will be located in a safe and confidential space when conducting our telemental health sessions. I also understand that it is important for me to find a safe and confidential space, free from other people (unless it is a family or couples session) on my end, from which to conduct our telemental health session.
* I understand that none of the telemental health sessions will be recorded or photographed. I agree not to make or allow audio or video recordings of any portion of the sessions.
* I understand that my therapist will confirm my identity and location at the beginning of each telemental health session.

**Emergencies:**

* I understand that if there is an emergency during a telemental health session, then my therapist may call emergency services and/or my emergency contact.

* I understand that if the video conferencing connection drops while I am in a session, I will have an additional phone line available to contact my therapist, or I will make additional plans with my therapist ahead of time for re-contact.

**Consent and Continuation of Therapy:**

* I understand that telemental health services are completely voluntary and that I can withdraw this consent at any time.
* I understand that I or my therapist may discontinue the telemental health sessions at any time if it is felt that the video technology is not a good fit for me or my therapy needs. I understand that if my therapist does in-person therapy, I may transfer to in-person therapy, if it is available at that time.

**Payment and Fees**:

* I understand that telemental health sessions are billed at the same rate to me and/or my insurance company as in-person sessions.
* I understand a “no show” or late fee will be charged if I miss an appointment or do not cancel within 24 hours of scheduled appointment.
* I understand credit card or other form of payment will be established before the first session.

**I hereby give my informed consent for the use of telemental health in my care.**

**Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Client Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth\_\_\_\_\_\_\_\_\_\_ Today’s Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State \_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_

Client’s Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client’s Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Name: (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature: (if applicable) : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* I have been offered a copy of this consent form (patient’s initials) \_\_\_\_\_\_\_