**Lilac City Counseling, Inc.**

**Information and Informed Consent for Telephonic Mental Health Treatment**

* I understand that telephonic mental health treatment is live two-way audio communications to enable therapists and clients to conduct therapy outside of the office setting.

**Benefits of Telephonic Mental Health:**

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

**Risks of Telephonic Mental Health:**

* I understand that telephonic mental 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:
* Calls can be “dropped” or cell phone service can be “spotty.”
* Smartphone hardware can have sudden failures or run out of power.
* Phone lines can be knocked down.
* I understand that telephonic mental health services have some increased risks to privacy.
* Cell phones have decreased privacy and security because their signals can be intercepted by others. I understand that use of
* A “land line” phone line is more secure than use of a cell phone.
* My therapist will inform me of whether she is using a cell phone or “land line” phone for our telephonic session.
* I understand that telephonic mental 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 telephonic mental health services.
* I understand that I will need to furnish my therapist with my email in order to transmit this Informed Consent document. 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 the laws that protect privacy and the confidentiality of client information also apply to telephonic mental health, and that no information obtained in the use of telephonic mental 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 telephonic mental 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 telephonic mental health session.
* I understand that none of the telephonic mental health sessions will be recorded. I agree not to make or allow audio recordings of any portion of the sessions.
* I understand that my therapist will confirm my identity and location at the beginning of each telephonic mental health session.

**Emergencies:**

* I understand that if there is an emergency during a telephonic mental health session, then my therapist may call emergency services and/or my emergency contact.
* I understand that if the telephone connection drops while I am in a session, my therapist will try to re-call me, or I will make additional plans with my therapist ahead of time for re-contact.

**Consent and Continuation of Therapy:**

* I understand that telephonic mental 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 telephonic mental health sessions at any time if it is felt that the phone 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.
* I understand that telephonic mental health services have only been approved as an emergency alternative form of therapy during the COVID-19 crisis and will likely not be available to me once the crisis is over.

**Payment and Fees**:

* I understand that telephonic mental health sessions are billed to me and/or my insurance company at the same rate 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 telephonic mental 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) \_\_\_\_\_\_\_