**L. Shannon Stephens, M.S., LPC, NCC**

3633 Wheeler Road • Suite 100 • Augusta, GA 30909 • Phone 706.364.0252 • Fax 706.364.0269 • www.cliniciansoffice.com

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

Telemental health services involve the use of electronic communications (telephone, video conference, etc.) to enable therapists to provide services to individuals remotely. Telemental health is a relatively recent approach to delivering care and there are some limitations compared with seeing a therapist in person. These limitations can be addressed and are usually minor depending on the needs of the client and the care with which the technology (cell phone, tablet, computer, etc.) is utilized.

**Timely notification:**

My intention is that telemental health be offered at my practice during the extent of the COVID-19 public health crisis. I cannot guarantee that services via telehealth will continue after this health emergency has abated.

**Additional Points for Client Understanding:**

* I understand that this form is signed in addition to the paperwork you completed as a new patient and does not change any of the *Client Consent for Counseling* documents I agreed to previously. (A copy of the new patient paperwork is available the office website at www.cliniciansoffice.come, if needed.)
* I understand that my Initial Consultation may not be done using telemental health.
* I understand that telemental health services are completely voluntary and that I can choose not to do it or not to answer questions at any time.
* I understand that none of the telemental health sessions will be recorded or photographed by my therapist without my written permission, and I understand that I may not record or photograph any of my telemental health sessions without the written permission of my therapist.
* 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 because this is a technologically-based method it may sometimes be necessary for a technician to assist with the equipment. Such technicians will keep any information confidential.
* I understand mental health is performed over a secure a communication system that is almost impossible for anyone else to access, but because there is still a possibility of a breach, I accept the very rare risk that this could affect confidentiality.
* I understand that there are risks from telemental health that may include but are not limited to the possibility despite all reasonable efforts by my provider: the transmission of medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; the electronic storage of my medical information could be accessed by unauthorized persons; and/or misunderstandings may occur more easily, particularly when care is delivered in an asynchronous manner.
* I understand that telemental health sessions will not be exactly the same as an in-person session due to the fact that I will not be in the same room as my therapist.
* I understand that I may experience benefits from the use of telemental health in my care, but that no results can be guaranteed or assured.
* I understand I am responsible for creating a safe, confidential space during sessions and I will engage in sessions in a private location where I cannot be heard or seen by others.
* I understand I am responsible for logging out or hanging up once sessions are complete.
* I understand you may contact me from a blocked number to avoid others knowing we have connected.
* I understand that if there is an emergency during a telemental health session, then my therapist will call emergency services and my emergency contact. I understand that if I do not follow safety/emergency protocols, my therapist has the right to discontinue use of teletherapy to protect my safety and well-being.
* I understand that if the video conferencing or telephone connection drops while I am in a session, I will provide a phone number (see below) for follow up contact if a plan for technical failures has not already been arranged with my therapist.
* I understand that I am required to provide an emergency contact (see below) in case of an emergency.
* I understand that telemental health-based services may not be appropriate for everyone seeking therapy. I also understand that if my therapist believes I would be better served by another form of therapeutic services (e.g. face-to-face services), she will make every effort under the circumstances of the COVID-19 health crisis to refer me to a practitioner who can provide such services in my area.
* I understand I may be requested to install applications specific to treatment onto my phone, tablet or computer device. Some applications specifically interact via phone /tablet, device, etc. and have the capability to report activity, GPS location, etc.
* I understand I have the right to withhold or withdraw this consent at any time. However, if I do so, this may require my therapist to provide referrals to other treatment providers if face-to-face services are not an option based on geography and/or circumstance.
* I understand the laws that protect the confidentiality of my personal health information also apply to telemental health, as do the limitations to that confidentiality discussed in the *Client Consent for* *Counseling* agreement. I also understand that the dissemination of any personally identifiable images or information from the telemental health interaction will not be shared without my written consent.
* I understand that email is not an appropriate means of communicating with my therapist in the case of emergency. I understand the email address provided below is to be used for providing this form only and is not an email that is monitored by my therapist. Any email address used by my therapist to engage in video conferencing is also not meant to be used in the case of an emergency or for counseling related content to be shared. I understand that email is not a secure communication medium for sensitive/personal information. I agree to call the office for scheduling, payments, insurance questions, or supplying other information.

**Emergency Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emergency Contact Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CANCELLATION/NO SHOW POLICY**

If you need to cancel an appointment, please follow the same procedure you already agreed to in your original *Client Consent for Counseling* documents. **As a reminder,** **cancellations should be made within 24 hours of your scheduled session time, unless you have a same day emergency arise. We understand this may be a more common occurrence in current times but please be sensitive to the needs of other patients needing appointments and the impact cancellations have on my practice now more than ever before.** Please call and inform our office of any same day emergencies. **If cancellation is not made within 24 hours, I reserve the right to charge a $65 fee in the same way a fee is charged for missing or late cancelling in-person sessions.**

**PAYMENT FOR SERVICES**

As with your face to face sessions, we will submit a claim to any insurance provider you gave us written consent to bill in your *Consent for Disclosure of Information to Third Party Payors* in the new patient paperwork completed at your first visit. Not all mental health services are a covered benefit in all insurance plans. However, it is our understanding at this time that most insurers are covering telemental health services during this emergency period. If you feel unsure, please contact your insurance company. **Patients are expected to pay for any part of charges not covered by insurance per usual procedure (i.e., copay, deductibles, etc.)**. Billing processes remain the same for telemental health services as with in office visits, as outlined in the *Client Consent for* *Counseling* document. Self-pay arrangements already in place will remain the same for teletherapy sessions. **It is preferable that payments are made by phone. The front office will call you to obtain your credit card information after your session concludes.** It is also possible I may need to help relieve the burden on the front office by collecting your credit card information during our sessions and process the payment later. If an alternative form of payment is needed, please discuss this with me. Please be patient with us as we do our very best to continue offering you counseling services in an ever-changing situation.

**CONSENT**

I consent to engaging in telemental health as part of my treatment with L. Shannon Stephens. I understand that “telemental health” includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of personal health information, and education using interactive audio, video, or data communications. I understand the information provided above regarding telemental health.

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

Name of Patient (Print) Email (Print) Cell Phone

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Signature of Patient

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Name of Legal Guardian [if patient under 18] (Print) Signature of Legal Guardian

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\*\*We want to make returning this form to our office as easy as possible amid the COVID-19 health crisis. If you are attending a session in person, bring the form with you or ask the front office for a copy. You may also download and sign the form and email it back to the office at [renee.rbgs@gmail.com](about:blank). If you have an easy way to scan your signed document and email it back to us, that’s great. If not, you may take a photo with your smartphone and email it. If you have access to a fax, our fax number is 706-364-0269. You may also download, sign, and mail it to our office at the address at the top of this document. Need help? Give us a call at 706-364-0252. Thank you!\*\*