Hope Springs Counseling, LLC
960 Broadway St NE, Suite 4
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Information and Consent to Telemental Health

Telemental Health is defined as: The provision of psychological services using telecommunication technologies. Telecommunications is the preparation, transmission, communication, or related processing of information by electrical, electromagnetic, electromechanical, electro-optical, or electronic means (Telemental Health Association).

Telemental Health, although not a new technology and therapists have been using various forms of technology-assisted media for many years, however breaches in security over recent years have made clear the need for added layers of protection in order to preserve confidentiality and to protect PHI (personal health information). There are other factors as well that you should be aware of including the delivery method utilized to offer telemental health at an acceptable, high level of care. I have undergone specialized training and study in telemental health and continue to do so in order to do my best to assure this high level of care. In addition to this I have adopted a number of practice policies and measures that help to protect that your PHI remains confidential. Please see below.

Limitations of Telemental Health Therapy Services

Telemental health services should not be understood as a complete substitute for in-office/in-person therapy. It is an alternative delivery method for therapy services and it involves limitations. For example, there may be a greater risk for misunderstanding one another due to missed visual or auditory cues due to technology glitches that may produce poorer visual or auditory quality. I do utilize a high quality, HIPPA compliant technology delivery system which provides for clarity in communication, but it is important to realize that the above issues as well as disruptions in service delivery can occur. These interruptions can be frustrating because they disrupt normal personal interaction that an in-person encounter allows.

I have the highest regard for your well-being and I strive for the highest level of care in every clinical encounter, but potentially these technology-related issues can limit my ability to deliver these as I do in-person/in-office. Please let me know immediately if you feel upset or confused by anything you believe I've said during a video session so that misunderstandings can be cleared up quickly.

Face-to-Face Requirement

If we agree that telemental health services are the *primary* way we choose to conduct sessions, I require one face-to-face meeting at the outset of treatment. I would greatly prefer that this meeting take place in my office. If this is not possible video conferencing may be substituted but I will require you to show a valid form of photo ID, and I will provide you with a password or pass number which you will use to identify yourself in all future sessions. This safeguards against someone else posing as you.

Your Responsibilities for Confidentiality & TeleMental Health

Please communicate only through devices that you know are secure as described above. It is also your responsibility to choose a secure location to interact with technology-assisted media and to be aware that family, friends, employers, coworkers, strangers, and hackers could either overhear your communications or have access to the technology that you are interacting with. Additionally, you agree not to record any telemental health sessions.

Our Agreement to Enter into a Therapeutic Relationship

Consent to TeleMental Health Services: Please check the telemental Health services you are authorizing me to utilize for your treatment or administrative purposes. Together, we will determine which modes of communicating are best for you. But please be aware that you may withdraw your authorization to use any of these services at any time during the course of your treatment by notifying me in writing. If you do not see an item discussed previously in this document listed for your authorization below, this is because it is built-in to my practice, and I will be utilizing that technology unless otherwise prearranged by you.

- ☐ Email
- ☐ Video Conferencing
- ☐ Website Portal
- ☐ Recommendations to Websites or Apps

Please print, date, and sign your name below indicating that you have read and understand the contents of this *"Information, Authorization and Consent to Treatment"* form. Your signature also indicates that you agree to the policies of your relationship with me, you are authorizing me to utilize the telemental health methods checked above, and you are authorizing me to begin this form of treatment with you.

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Client Name (Please Print) **Date**

_____

Client Signature

If Applicable:

_____

Parent's or Legal Guardian's Name (Please Print) **Date**

_____

Parent's or Legal Guardian's Signature

My signature below indicates that I have discussed this form with you and have answered any questions you have regarding this information.

_____

Clinician Signature **Date**