# **TELEHEALTH PSYCHOTHERAPY**

# **CONSENT TO TREATMENT**

Dear Client,

It is important in beginning our professional relationship to understand both the nature and limitations of the relationship. Please review the following policies to understand these areas:

**CONFIDENTIALITY.** The therapy relationship is both a professional and confidential relationship protected by professional and ethical standards, to the extent that, with a few important exceptions, what you disclose is confidential and cannot be released without your written consent. However, there are certain circumstances under which we are ethically and/or legally required to disclose information. These include the following:

1. If there is a reasonable belief that child, elder or dependent adult abuse has occurred.
2. If you make a threat to harm a third party and/or you pose a risk to yourself or others.

You should also be aware your confidentiality can be waived if you tender your mental condition in civil or criminal limitation. Thus, the decision of whether to tender your mental condition is an issue you should consult your attorney on.

**APPOINTMENTS.** Once an appointment is made that time has been reserved solely for you. If you find you are unable to keep your appointment, it is your responsibility to notify us and cancel your appointment at least 24 hours in advance (48 hours is greatly appreciated). Failure to cancel 24 hours in advance will result in a $80 charge.

**PAYMENTS/FEES POLICY.** Clients are expected to pay for services at the time they are rendered unless other arrangements have been made. Clients who carry insurance should remember professional services are rendered and charged to the patient and not to the insurance company. We will gladly provide you with a receipt, which you can submit to your insurance company for reimbursement and fill out any necessary forms. We accept cash or checks. There is a $40.00 charge for checks with insufficient funds.

**COLLECTIONS POLICY.** In the event you fail to make reasonable efforts to pay your bill, our office retains the right to pursue delinquent accounts. Our office will make every effort to work out a reasonable payment arrangement should you request that. However, patients who refuse to will have their accounts transferred to our collection agency. If it becomes necessary to transfer your account to our collection agency, your financial records will be released and your delinquent balance will be recorded with TRW. Please be aware we take this action only as a last resort.

**BENEFITS AND RISKS OF TELEHEALTH.**

Telepsychology refers to providing psychotherapy services remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits of telepsychology is that the client and clinician can engage in services without being in the same physical location. This can be helpful in ensuring continuity of care if the client or clinician moves to a different location, takes an extended vacation, or is otherwise unable to continue to meet in person. It is also more convenient and takes less time. Telepsychology, however, requires technical competence on both our parts to be helpful. Although there are benefits of telepsychology, there are some differences between in-person psychotherapy and telepsychology, as well as some risks.

**TELEHEALTH IN CASE OF EMERGENCY.** If a need for direct, face to face services arises, it is my responsibility to contact practitioners in my area such as through the SB COUNTY ACCESS LINE 1-888-868-1649 SLO COUNTY ACCESS LINE 1-805-838-1381, or to contact my behavioral health practitioner’s office for a face to face appointment or my primary care provider if my behavioral health practitioner is unavailable. I understand that an opening may not be immediately available in either office.

1. I may decline any telehealth services at any time without jeopardizing my access to future care, services or benefits.

2. These services rely on technology, which allows for greater convenience in service delivery. There are risks in transmitting information over technology that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties. My practitioner and I will regularly reassess the appropriateness of continuing to deliver services to me through the use of the technologies we have agreed upon today, and modify our plan as needed.

3. In emergencies, in the event of disruption of services, or for routine or administrative reasons, it may be necessary to communicate by other means:

a. In emergency situations: please contact 911 or go to the nearest emergency room or Urgent Care.

 b. Service disruption: please call me at 805-266-3231

 c. For other communication: please email me at TragaLarisa@gmail.com

I acknowledge, however, that if I am facing or if I think I may be facing an emergency situation that could result in harm to me or to another person; I am not to seek a telehealth consultation. Instead I agree to seek care immediately through my own local health care practitioner or at the nearest hospital emergency department or by calling 911.

I have received a copy of my practitioner’s contact information, including his/her name, telephone number, business address, mailing address, and email address (if applicable). I have also been provided with a list of local support services in case of an emergency. I am aware that my practitioner may contact the proper authorities and/or my designated local contact person in case of an emergency.

4. My practitioner may utilize alternative means of communication in the following circumstances: video connections fail or phone line access is disrupted.

5. My practitioner will respond to communications and routine messages within 48 hours on business days or on the next business day following weekends, holidays, or vacations.

6. It is my responsibility to maintain privacy on the client end of communication. Insurance companies, those authorized by the client, and those permitted by law may also have access to records or communications.

 7. I will take the following precautions to ensure that my communications are directed only to my behavioral health practitioner or other designated individuals: Double check email addresses; double check phone numbers; double check to whom email is sent (reply vs reply all).

8. My communication with my behavioral health practitioner will be stored in the following manner: In compliance with HIPAA regulations in secured file cabinets and/or secured electronic medical record files.

9. The laws and professional standards that apply to in-person behavioral services also apply to telehealth services. This document does not replace other agreements, contracts, or documentation of informed consent.

I have read the above policies and understand what it says. If I have any

questions regarding these policies I will ask my therapist to clarify these policies.

Your signature below indicates agreement with its terms and conditions.

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Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist Date

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

Name of Emergency Contact Date Phone Number

 (Date)