

Laura Root, LCSW

Informed Consent for TeleMental Health Services

The following information is provided to clients who are seeking TeleMental Health therapy. This document covers your rights, risks and benefits associated with receiving services, my policies, and your authorization. Please read this document carefully, note any questions you would like to discuss, and sign.

TeleMental Health Defined:

TeleMental Health means the remote delivering of health care services via technology-assisted media. This includes a wide array of clinical services and various forms of technology. The technology includes but is not limited to, a telephone, video, internet, a smartphone, tablet, PC desktop system or other electronic means. The delivery method must be secured by two-way encryption to be considered secure. Synchronous (at the same time) secure video chatting is the preferred method of service delivery.

Limitations of TeleMental Health Therapy Services:

While TeleMental Health offers several advantages such as convenience and flexibility, it is an alternative form of therapy or adjunct to therapy and thus may involve disadvantages and limitations. For example, there may be a disruption to the service (e.g., phone gets cut off or video drops). This can be frustrating and interrupt the normal flow of personal interaction. Primarily, there is a risk of misunderstanding one another when communication lacks visual or auditory cues. For example, if video quality is lacking for some reason, I might not see various details such as facial expressions. Or, if audio quality is lacking, I might not hear differences in your tone of voice that I could easily pick up if you were in my office.

Additionally, the therapy office decreases the likelihood of interruptions. However, there are ways to minimize interruptions and maximize privacy and effectiveness. As the therapist, I will take every precaution to insure technologically secure and environmentally private psychotherapy sessions. As the client, you are responsible for finding a private quiet location where the sessions may be conducted. Consider using a “do not disturb” sign/note on the door. The virtual sessions must be conducted on a wifi connection for the best connection and to minimize disruption.

In Case of Technology Failure:

I use Google Meet Application for my telehealth video sessions, please download application on your device before your session.

I understand that, during a TeleMental Health session, we could encounter a technological failure. Difficulties with hardware, software, equipment, and/or services supplied by a third party may result in service interruptions. If something occurs to prevent or disrupt any scheduled appointment due to technical complications and the session cannot be completed via online video conferencing, I will call you at the number you have provided. Please make sure you have a phone with you, and I have that phone number. We may also reschedule if there are problems with connectivity.

Structure and Cost of Sessions:

I offer face-to-face psychotherapy when appropriate and available, that is, based on your ability to make in-person sessions and my availability. I may provide virtual psychotherapy if your treatment needs determine that TeleMental Health services are appropriate for you. If appropriate, you may engage in either face-to-face sessions, TeleMental Health, or both. We will discuss what is best for you. Please remember that your insurance company may or may not cover therapy via phone or video. We are both responsible for understanding your mental health benefits. Please contact your insurance provider to verify coverage via TeleMental Health.

The structure and cost of TeleMental Health sessions are exactly the same as face-to-face sessions.

Cancellation Policy:

In the event you are unable to keep either a face-to-face appointment or a TeleMental Health appointment, you must notify me at least 24 hours in advance. If such advance notice is not received, you will be financially responsible for the session you missed. Please note that insurance companies do not reimburse for missed sessions.

I agree to take full responsibility for the security of any communications or treatment on my own computer or electronic device and in my own physical location. I understand I am solely responsible for maintaining the strict confidentiality of my user ID, password, and/or connectivity link. I shall not allow another person to use any user ID or connectivity link to access the services. I also understand that I am responsible for using this technology in a secure and private location so that others cannot hear my conversation.

I understand that there will be no recording of any of the online sessions and that all information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without my written permission, except where disclosure is required by law.

Consent to Treatment

I voluntarily agree to receive online therapy services for an assessment, continued care, treatment, or other services and authorize Laura Root, LCSW to provide such care, treatment, or services as are considered necessary and advisable. I understand and agree that I will participate in the planning of my care, treatment, or services and that I may withdraw consent for such care, treatment or services that I receive at any time. By signing this Informed Consent, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

Please know that I have the utmost respect and positive regard for you and your wellbeing. I would never do or say anything intentionally to hurt you in any way. I strongly encourage you to let me know if something I've done or said has upset you. I invite you to keep our communication open at all times to reduce any possible harm. Please use technology with discretion. Only communicate limited information such as appointment requests, cancellations, or estimate time of arrival.

I consent to the use of the following forms of communication via technology:

_____ Texting _____ Email _____ Fax _____ Recommendations to Websites or Apps

Patient/Client Signature

Date _____

Parent, Guardian or Legal Representative Signature
(if minor or needed otherwise)

Date _____

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

Date _____