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

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**TeleMental Health Defined**

TeleMental health means the remote delivering of mental 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, telephone, video, internet, smartphone, tablet, PC (Personal Computer) 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, the therapist might not see various details such as facial expressions. Or, if audio quality is lacking, the therapist might not hear differences in your tone of voice that could easily be pick up if you were meeting in the therapy office.

Additionally, the therapy office decreases the likelihood of interruptions. However, there are ways to minimize interruptions and maximize privacy and effectiveness. The therapist will take every precaution to insure technologically secure and environmentally private psychotherapy sessions. As the client, you are responsible for finding a private quite 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 Wi-Fi connection for the best connection and to minimize disruption.

**In Case of Technology Failure**

It is understood, during a TeleMental health session we could encounter a technological failure. Difficulties with hardware, software, equipment, and/or services supplied by a 3rd 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, please call the therapist back at: **760-895-0202**. Please make sure you have a phone with you, and the therapist has that phone number. We may also reschedule if there are problems with connectivity.

**Structure of Sessions**

The therapist offers face-to-face psychotherapy/group therapy primarily when an individual is appropriate for such services. However, as a result of the current COVID-19 pandemic and restrictions placed on in person therapeutic services, the therapist may provide virtual psychotherapy if your treatment needs determine TeleMental health services are appropriate for you. If appropriate, you may engage in TeleMental health services individually, in group sessions, or both. We will discuss what is best for you and your preference.

The structure and costs of TeleMental health sessions are exactly the same as face-to-face sessions described in the organization’s general intake forms.

**Email**

Email is not a secure means of communication and may compromise your confidentiality. We realize many people prefer to email because it is a quick way to convey information. Nonetheless, please know, it’s an organizational policy to utilize this means of communication strictly for appointment confirmations. You may also contact the therapist at **760-895-0202** to schedule, reschedule, or cancel an appointment. Please do not bring up any therapeutic content via email to prevent compromising your confidentiality. It is important to know that therapists are required to keep a copy or summary of all emails as part of your clinical record that address anything related to therapy. It also strongly suggested that you only communicate through a device that you know is safe and technologically secure (e.g., has a firewall, anti-virus software installed, is password protected, not accessing the internet through a public wireless network, etc.). If you are in a crisis, please do not communicate this via email because it may not be seen in a timely manner. Instead, please follow the "**Emergency Management Plan**”, found below.

**Cancellation Policy**

In the event that you are unable to keep either a face-to-face appointment or a TeleMental health appointment, you must notify the therapist at least 24 hours in advance. If such advance notice is not received, it will count as a “No Show”. After three (3) “No Shows” you will no longer be eligible for individual therapy services. If this circumstance occurs, you will be provided with additional resources at that time.

**Emergency Management Plan**

If the therapist is unavailable, in the event of an emergency, or if there is an interruption/disconnection in the method of TeleMental health communications, it is imperative you are aware of resources in your area.

You may alternatively follow this plan:

1. Call RI Crisis Line for Riverside County at (442) 268-7000

2. Call 911.

3. Go to the emergency room of your choice.

As a precaution, please identify one (1) nearby emergency service provider below you could contact in the event of an emergency. This could be another therapist you are currently working with, hospital, primary care physician, etc.

**List one (1) nearby emergency service provider:**

1. Service Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency Contact**

**In addition, you will need to provide information for an emergency contact person. These all must be completed in order to participate in TeleMental health services.**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**You agree to take full responsibility for the security of any communications or treatment on your own computer or electronic device and in your own physical location.**

You understand you are solely responsible for maintaining the strict confidentiality of your user ID, password, and/or connectivity link. You shall not allow another person to use your user ID or connectivity link to access the services.

You also understand that you are responsible for using this technology in a secure and private location so that others cannot hear your conversation. This is especially important if you are participating in online Group Sessions. If you are unable to secure a completely private location, please utilize headphones, if needed. If you are unable to ensure others at your location are not interrupting or are present, you may not be eligible to participate in these specific types of TeleMental Health services. You understand the online session will not and are not to be recorded. All information disclosed within sessions and all written records pertaining to those sessions are confidential. They may not be revealed to anyone without written permission, except where disclosure is required by law.

**Consent to Treatment**

You voluntarily agree to receive online therapy services for an assessment, continued care, treatment, or other services and authorize, our therapist: **Angie Negro, LCSW** to provide such care, treatment, or services as are considered necessary and advisable. You understand and agree that you will participate in the planning of you care, treatment, or services. You may withdraw consent for such care, treatment, or services that you receive at any time.

Please use technology with discretion. Only communicate limited information, such as appointment request, cancellations, or estimated time of arrival via email/written communications. You must inform the therapist in advance if you will be participating in Telemental Health services at any location other than the address on file. Out of state Telemental Health service delivery will require approval from the therapist and state in which you are located prior to participation to ensure that such service is legally permitted.

By signing this ***Informed Consent***, you, the undersigned client, acknowledge you have read, and understood, all the terms and information contained herein. Ample opportunity has been offered to you to ask questions and seek clarification of anything unclear to you.

**You consent to the use of the following forms of communication via technology:**

\_\_\_ Email

\_\_\_ Fax

\_\_\_ Zoom Platform for TeleMental health

\_\_\_Phone

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 Client Name (Print Name) Date

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Client Signature

The therapist’s signature below indicates the therapist has discussed this form with you and has answered any questions you have regarding this information.

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Therapist Name (Print Name) Date

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