

**Confidential Care  
TeleMental Health Consent Form**

Video Conferencing (VC): Video Conferencing is an option for us to conduct remote sessions over the internet where we not only can speak to one another, but we may also see each other on a screen. I use Doxy.Me. VC platform is encrypted to the federal standard, HIPAA compatible, and has signed a HIPAA Business Associate Agreement (BAA). The BAA means that Doxy.Me is willing to attest to HIPAA compliance and assumes responsibility for keeping our VC interaction secure and confidential. If we choose to utilize this technology, I will give you detailed directions regarding how to log-in securely. I also ask that you please sign on to the platform at least five minutes prior to your session time to ensure we get started promptly. Additionally, you are responsible for initiating the connection with me at the time of your appointment.

I strongly suggest that you only communicate through a computer or device that you know is safe (e.g., has a firewall, anti-virus software installed, is password protected, not accessing the internet through a public wireless network, etc.).

**Emergency Procedures Specific to TeleMental Health Services**

There are additional procedures that we need to have in place specific to TeleMental Health services. These are for your safety in case of an emergency and are as follows:

1. You understand that if you are having suicidal or homicidal thoughts, experiencing psychotic symptoms, or in a crisis that we cannot solve remotely, I may determine that you need a higher level of care and TeleMental Health services are not appropriate.

2. I require an Emergency Contact Person (ECP) who I may contact on your behalf in a life-threatening emergency only. Please write this person's name and contact information below. Either you or I will verify that your ECP is willing and able to go to your location in the event of an emergency. Additionally, if either you, your ECP, or I determine necessary, the ECP agrees take you to a hospital. Your signature at the end of this document indicates that you understand I will only contact this individual in the extreme circumstances stated above.

Please list your ECP here:

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

3. You agree to inform me of the address where you are at the beginning of every TeleMental Health session.

4. You agree to inform me of the nearest mental health hospital to your primary location that you prefer to go to in the event of a mental health emergency (usually located where you will typically be during a TeleMental Health session). Please list this hospital and contact number here:

Hospital: \_\_\_\_\_ Phone: \_\_\_\_\_

**In Case of Technology Failure**

During a TeleMental Health session, we could encounter a technological failure. The most reliable backup plan is to contact one another via telephone. Please make sure you have a phone with you, and I have that phone number. If we get disconnected from a video conferencing or chat session, end and restart the session. If we are unable to reconnect within ten minutes, please call me.

If we are on a phone session and we get disconnected, please call me back or contact me to schedule another session. If the issue is due to my phone service, and we are not able to reconnect, I will not charge you for that session.

### **Structure and Cost of Sessions**

The therapist and/or Psychiatric Mental Health Nurse Practitioner (PMHNP) may provide phone, and/or video conferencing 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.

The structure and cost of TeleMental Health sessions are the same as face-to-face sessions. The therapist will provide TeleMental Health therapy for a specified fee that is equivalent to an in-office appointment.

**FEES FOR SERVICES ARE SUBJECT TO CHANGE; PLEASE REVIEW CURRENT FEES FOR MOST UP-TO-DATE SERVICE CHARGES. YOU WILL BE RESPONSIBLE FOR ALL FEES NOT COVERED BY YOUR INSURANCE CARRIER.**

Our office provides a 20% discount from these prices for self-pay clients or clients whose insurance carrier doesn't cover for this service.

Our office requires a credit card ahead of time for TeleMental Health therapy for ease of billing. You will be required to sign the Credit Card Payment Form that indicates that Confidential Care may charge your card without you being physically present. Your credit card will be charged at the end of each TeleMental Health interaction for self-pay clients and for clients whose insurance carrier does not reimburse for such TeleMental services. Visa, MasterCard, Discover, or American Express are acceptable for payment, and our office will provide you with a receipt of payment.

Insurance companies have many rules and requirements specific to certain benefit plans. Now, many do not cover TeleMental Health services. It is your responsibility to find out your insurance company's policies. Our office will file for insurance reimbursement for TeleMental Health services if your policy covers this service. You are also responsible for the cost of any technology you may use at your own location. This includes your computer, cell phone, tablet, internet or phone charges, software, headset, etc.

### **Cancellation Policy**

If you are unable to keep either a face-to-face appointment or a TeleMental Health appointment, you must notify our office at 907-357-1999 at least 24 hours in advance. If such 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.

### **Limitations of TeleMental Health Therapy Services**

TeleMental Health services should not be viewed as a complete substitute for therapy conducted in our offices at Confidential Care, unless there are extreme circumstances that prevent you from attending therapy in person. It is an alternative form of therapy or adjunct therapy, and it involves limitations. 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 a tear in your eye. Or, if audio quality is lacking, I might not hear the crack in your voice that I could easily pick up if you were in my office. There may also 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. 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, and 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 always to reduce any possible harm.

### **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 onset of treatment. I prefer for this initial meeting to take place in my therapy office. If that is not possible, we can utilize video conferencing as described above. During this initial session, I will require you to show a valid picture ID and another form of identity verification such a credit card in your name. At this time, you will also choose a password, phrase, or number which you will use to identify yourself in all future sessions. This procedure prevents another person from posing as you.

### **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 ultimately determine which modes of communication are best for you. However, you may withdraw your authorization to use any of these services at any time during your treatment just 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 our practice, and I will be utilizing that technology unless otherwise negotiated by you.

Email

Video Conferencing

Recommendations to Websites or Apps

In summary, technology is constantly changing, and there are implications to all the above that we may not realize at this time. Feel free to ask questions, and please know that I am open to any feelings or thoughts you have about these and other modalities of communication and treatment.

### **Communication Response Time**

My practice is an outpatient facility, and I am set up to accommodate individuals who are reasonably safe and resourceful. I do not carry a beeper nor am I available always. If at any time this does not feel like sufficient support, please inform me, and we can discuss additional resources or transfer your case to a therapist or clinic with 24-hour availability. I will return phone calls within 24 hours. However, I do not return calls or emails on my days off, weekends or holidays. If you are having a mental health emergency and need immediate assistance, please follow the instructions below.

### **In Case of an Emergency**

If you have a mental health emergency, I encourage you not to wait for communication back from me, but do one or more of the following:

- Call Providence Hospital in Anchorage for Psychiatric emergency: 907-212-2800 or  
Crisis Line: 907-563-3200
- Call Alaska Psychiatric Institute (API) in Anchorage: 907-269-7800
- Call Veteran's Hotline if a veteran: 800-273-TALK (8255)
- Call 911.
- Go to the emergency room of your choice.

Please date, and sign your name below indicating that you have read and understand the contents of this form, you agree to these policies, and you are authorizing me to utilize the TeleMental Health methods discussed.

\_\_\_\_\_  
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