

SHOMAN CENTER FOR STRESS MANAGEMENT, LLC

Technology within a Therapeutic Setting: Consent, Policies, Limitations, and Agreement Form

This form is to review the limitations, risks, and benefits of technology within a therapeutic setting. This includes email, phone, text and video. I will ultimately determine if you are appropriate for this type of treatment.

Benefits:

The benefits to technology are:

1. Reduces the stigma of obtaining mental health services
2. More convenient for clients to get the help they need
3. Reduces the overall costs due to not having to drive to and from an office
4. Reduces the wait time for scheduling office appointments
5. Increased availability of services to people who are unable to leave the home or have transportation issues.

Limitations:

It is important to note that there are limitations to technology that can affect the quality of the session(s). These limitations include but are not limited to the following:

1. Because we are not in person, I have limitations to reading your body language and non-verbal reactions.
2. Due to technology limitations, I may not hear everything that you say. If you feel I have not heard you, please make sure to repeat what was stated.
3. Technology may fail before or during the session.
4. Although every effort is made to reduce confidentiality breeches, we are using technology platforms and I do not have any control over whether or not the protection of HIPAA confidentiality used by the platform is working.
5. I will inform you of which technology platform we are using and it is your responsibility to read, understand, and agree to their specific rules and limitations.

Logistics:

When I am using technology, I will be in a private location to ensure your privacy. It is your responsibility to be in a location that is safe and confidential to protect your privacy. It is advisable for you to be in a room by yourself with the door to the room closed. If you choose a place where others can hear you, I cannot be responsible for protecting your confidentiality. Every effort MUST be made on your part to protect your own confidentiality.

Connection Lost:

If we lose our connection during a video or phone session, I will contact you to try and troubleshoot the reason for the lost connection. If the reason the connection is lost occurs on your part (i.e. battery dying, bad reception, etc.), you may still be charged for the entire session. If the loss for connection is a result of something caused by me, I will do everything I can to troubleshoot the problem and may offer other options such as completing the session using other technology, or may need to reschedule.

Recording of Sessions:

Please note the recording of audio/video, photographing, screenshots, streaming, etc. of any kind is NOT permitted and are grounds for termination of the client-therapist relationship.

Your Location:

I am only licensed to practice in the state of Arizona. That means you must reside in Arizona and be participating from the state of Arizona during our sessions. You agree to inform me if your location has changed.

In Case of Emergencies:

Before each session begins, I will request the address at which you are currently located and will use this information to give to authorities in case of a crisis or emergency. If for some reason you and I get disconnected and you are in crisis/emergency, you agree to call 911, go to your local emergency room immediately or contact the National Suicide Hotline 800-273-TALK (8255). If I have concerns about your safety, including being a danger to yourself or others at ANYTIME during a session, I will call 911.

I am required to keep an emergency contact for you. This contact can/will be used during a crisis/emergency.

Please list the person’s first and last name, relationship and phone number(s) of your emergency contact:

Full Name/ Relationship/ Number(s)

Full Name Relationship Number(s)

Please list any alternate numbers at which you may be contacted in case of a crisis/emergency:

Number(s)

Consent to participate in technology within a therapeutic setting:

By signing below, you agree that you have read and understand all of the above sections of **Technology within a Therapeutic Setting Informed Consent**. You agree that you also understand the limitations associated with technology within a therapeutic setting and consent to attend sessions under the terms described above in this document.

You agree that you have been given the choice to receive behavioral health services via telemedicine. You understand that your participation in telemedicine is voluntary and you may refuse to participate or decide to stop participation at any time. You understand that your agreement/refusal to participate or decision to stop participation will be documented in your medical record.

Please circle the appropriate statement below:

I AGREE TO PARTICIPATE IN AND RECEIVE BEHAVIORAL HEALTH SERVICES VIA TELEMEDICINE.

I HAVE CHOSEN NOT TO PARTICIPATE IN TELEMEDICINE SESSIONS.

Printed Name: _____

Signature: _____

Date: _____

Witness Signature/Date: _____