



## **INFORMED CONSENT ADDENDUM FOR TELEMENTAL HEALTH**

**This is to be used in conjunction with, but does not replace, the Informed Consent document that is required of all clients prior to starting therapy services.**

### *What is Telemental Healthcare?*

Telemental healthcare includes the practice of diagnosis, treatment, education, goal setting, accountability, referral to resources, problem solving, skills training, and help with decision making through the use of internet-based videoconferencing. Telehealth psychotherapy may include psychological health care delivery, consultation, coaching, and/or counseling. Telehealth psychotherapy will occur primarily through interactive audio, video, and telephone communications.

### *Risks of Telemental Health*

1. Technological failure, such as unclear video, loss of sound, poor connection, or loss of connection.
2. Nonverbal cues are less readily available to both the therapist and the client.
3. May be harder to feel safer in communicating and maintain confidentiality.

### *Benefits of Telemental Health*

1. Less limitations by geographical location.
2. Reduction of travel to a physical office, which includes decrease in travel time.
3. Participation in therapy from your own home or the environment of your choosing.

Telemental health delivery by Resolute Counseling may occur only with current residents of Pennsylvania. The current laws that protect privacy and confidentiality also apply to telemental health. All existing laws regarding client access to mental health information and copies of mental health records apply. No permanent video or voice recordings are kept from telemental health sessions. Clients may not record or store videoconference sessions or face-to-face sessions.

### *Expectations of client during each session*

1. Minimum bandwidth connection of 384 kb or higher.
2. Minimum resolution of 640x360 at 30 frames per second.
3. Operational web camera (HD 1080p is recommended).
4. Proper lighting and seating to ensure a clear image of each party's face.
5. Dress and environment appropriate to an in-office visit.
6. Only agreed upon participants will be present. The presence of any individuals unapproved by both parties and not part of the treatment plan will be cause for termination of the session.
7. Valid ID must be presented by the client during the initial consultation. In addition, a copy must be provided by the client for the medical file. Also, if client is using insurance, a copy of the insurance card must be provided.
8. The client must disclose the physical address of their location at the start of the session. Unknown locations will be cause for termination of the session.
9. The client shall also provide a phone number where they can be reached in the event of service disruption.



Telemental health may not be the most effective form of treatment for certain individuals or presenting problems. If it is believed the client would benefit from another form of service (e.g. face-to-face sessions) or another provider, an appropriate referral will be made. If it would be beneficial for occasional face-to-face sessions with one of our counselors, this will be discussed as part of the treatment plan and the client has the right to refuse such a recommendation. This may result in a referral to another provider/agency as well.

#### *Emergency protocol*

Client is to provide the name and contact information for an additional person in case of emergency on our questionnaire. In addition, in the event of a medical or mental crisis event, Resolute Counseling will contact the client's local emergency services. The information provided will include the nature of the crisis and immediate needs of the client.

#### *Response to technical difficulties*

Should technical difficulties cause session disruption, your counselor will contact the client via preferred telephone contact. If the technical difficulties can be resolved quickly, the session will resume and the client will not experience a shortened session length. If the technical issues cannot be resolved in a timely manner, the session will be rescheduled for a time when functionality is restored. The client will be contacted by telephone to develop a plan for continuation of the session.

#### *Payment*

Session costs are outlined in the Service Agreement. The cost for self-pay sessions is \$90 for 60-minute session. If you are using insurance, your benefits will be checked and we will do our best to give you an expectation of your responsibility. We do not always know the true amount of the client's responsibility until billing comes back after a claim has been filed. Payment for services is to be made at, or prior to, the time of service via credit card. A preferred credit card will be stored on-file in our electronic medical records system (TherapyNotes). You can read more about TherapyNotes by visiting, [www.therapynotes.com](http://www.therapynotes.com)

See the service agreement and our website ([www.resolutecounseling.com](http://www.resolutecounseling.com)) for a more detailed discussion of session cost and payment.

#### *Contact between sessions*

Telephone contact can be made in between sessions for the purposes of scheduling or other needs. Videoconference technology is reserved for therapy sessions only.

#### *Consent to Treatment*

I, voluntarily, agree to receive Telemental Healthcare assessment, care, treatment, or services and authorize Resolute Counseling 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 through Resolute Counseling 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.

\_\_\_\_\_  
Name of Client or Legal Representative

\_\_\_\_\_  
Signature of Client or Legal Representative

\_\_\_\_\_  
Relationship to client

\_\_\_\_\_  
Date

Please send a copy of the therapist-signed addendum to any of the following:

Address: \_\_\_\_\_

Email address: \_\_\_\_\_

(only include email address if you are authorizing this as an acceptable means of communication)

\_\_\_\_\_  
Signature of Therapist

**Please note: You can electronically sign this document through our patient portal. Your electronic signature will be verification of your approval of the information in this document and will provide and signature and date.**

**If you prefer to hand-sign this document, please print out, sign, and send:**

- 1. Email to [michael@resolutecounseling.com](mailto:michael@resolutecounseling.com)**
- 2. Secure Fax to 717-264-0450**
- 3. Mail to 38 Black Avenue, Chambersburg, PA 17201**