

Smith Psychotherapy Associates, S.C.

Robert J. Smith, LCSW - Daniel C. Smith, LCSW
Rachel S. Nitzarim, PhD - Anastasia Baran, LCSW

Consent for Tele-Mental Health & Video Conferencing

I _____, understand that my health care provider, _____

_____, offers to engage in tele-mental health sessions.

- They explained to me how the tele-mental health conferencing technology that will be used will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my provider.
- I understand that tele-mental health sessions have potential benefits including easier access to care and the convenience of meeting from a private location of my choosing.
- I understand that there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider will take reasonable steps to ensure my privacy. I will make sure to find a private place for sessions where I will not be interrupted. I will protect the privacy of sessions on my cell phone, computer, or other device. I will participate in psychotherapy only while in a room or area where other people are not present and cannot overhear the conversation. I understand that my health care provider or I can discontinue the tele-mental health visit/session if it is felt that the videoconferencing connections are not adequate for the situation.
- I have had a direct communication with my provider, during which I had the opportunity to ask questions regarding this procedure. My questions have been answered, and the risks, benefits, and any practical alternatives have been discussed with me so that I understand.
- I understand that tele-mental health sessions are not meant for crisis situations. Assessing and evaluating threats and other emergencies can be more difficult when conducting tele-mental health than in traditional in-person therapy. If the session is interrupted for any reason, such as the technological connection fails, and I am having an emergency, I know not to call my health care provider back; instead I will:
 - Call 911
 - Call the National Crisis Lifeline at 800-273-8255
 - Text the Crisis Text Line "Home" to 741741
 - Or, go to the closest emergency room.
 - Once safe, I will call my tele-mental health care provider and let them know of my status.
- I understand that the same rate fees apply for tele-mental health. If using insurance, I understand that whatever my insurance benefit does not pay for, I am solely responsible for.
- I understand that tele-mental health sessions shall not be recorded in any way unless agreed to in writing by mutual consent. My mental health care provider will maintain a record of our session in the same way records are maintained for in-person sessions in accordance with the practice's policies.

241 Golf Mill Center, Ste. 708 Niles, Illinois 60714 - Ph. (847) 824-8366 – Fax. (847) 824-8367

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Individual, Marital, Family Therapy - Clinical Hypnosis
Mindfulness Practices For Mental Health, Trauma & Health Conditions

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- I understand this agreement is intended as a supplement to the general informed consent that was agreed to at the outset of treatment and does not change any of the terms of that agreement.

CONSENT TO USE THE TELE-MENTAL HEALTH

Tele-mental health by **Doxy.me** is the HIPAA compliant technology service we will use to conduct tele-mental health conferencing appointments. It is simple to use and there are no passwords required to log-in.

By signing this document, I acknowledge:

- Tele-mental health by **Doxy.me** is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
- Though my provider and I may be in direct, virtual contact through the Tele-mental health Service, neither **Doxy.me** nor the Tele-Mental Health Service provides any Tele-mental health services or advice including but not limited to, emergency or urgent services.
- The Tele-mental health services by **Doxy.me facilitates videoconferencing** and is **not** responsible for the delivery of any other healthcare service.
- I **do not** assume that my provider has the access to any or all of the technical information in the Tele-Mental Health by **Doxy.me** service – or that such information is current, accurate or up-to-date. I will **not** rely on my health care provider to have any of this information in the Tele-Mental Health by **Doxy.me** service.
- To maintain confidentiality, I will not share my tele-mental health appointment link with anyone unauthorized to attend the appointment.

By signing this form, I _____ certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

By SIGNING BELOW, I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Client Signature _____ Date: _____

Therapist Signature _____ Date: _____

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