CONSENTS FOR TELEHEALTH THERAPY SERVICES

Thrive Mental Health Services
106 Mission Ct., Ste 102B, Franklin, TN 37067
Tel./Text: (615) 499-8636 / Fax: (615) 261-8898/ email: therapy@thrivemhs.com

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CONSENT TO CONDUCT OUTPATIENT PSYCHOTHERAPY SESSIONS VIA TELEHEALTH

1. **I understand that my health care provider wishes me to engage in a telehealth psychotherapy session.**
2. My health care provider explained to me how the video conferencing technology that will be used to affect such a psychotherapy session and thus it has pros and cons. For example:
   - Telehealth is **not be exactly the same** as an in-person direct client/health care provider session, in that **I will not be in the same room as my provider. And because of this, there are limitations to what the provider can see/hear and what the client can see/hear.**
   - **Telehealth psychotherapy can make it easier access to care AND to designate a meeting location/time of my choosing which is more convenient for me.**
   - **I have had a direct conversation with my provider**, during which I had the opportunity to ask questions in regard to this procedure. **My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.**

   Notes/Comments:____

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3. **I understand that my therapist or I can discontinue utilizing telehealth for psychotherapy if** (based upon either due to my therapist's clinical judgement OR my own judgement) **it is deemed that utilizing telehealth as a modality is adequate for the situation and my needs.**
4. **I understand that if I am not Self-Pay, that it is MY RESPONSIBILITY to communicate with:**
   - ☐ **my Employee Assistance Plan (EAP) &/or**
   - ☐ **my Insurance plan to ensure** that my Telehealth Outpatient Psychotherapy sessions **will be either:**

     ☐ **completely paid by my insurance plan (100%) OR**

     ☐ **partially paid (with either a Coinsurance _____% or Copay $______), if not paying toward a Deductible, by Insurance Plan.**

     Notes:____

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5. **I also understand that,** if I am paying toward a Deductible with my insurance plan, that it is **MY RESPONSIBILITY to communicate with my insurance plan to ensure that:**
   - **The Payments that I make to my provider** for Telehealth Outpatient Psychotherapy sessions **will ☐ actually be applied toward my Deductible by my insurance plan.**
6. **If my EAP &/or Insurance Plan does NOT cover Telehealth Outpatient Psychotherapy, but I still want to utilize Telehealth, I have the option to work with my provider to Negotiate a Self-Pay Rate** per Session that both works with my budget AND reflects the value of the service that my therapist provides to me.
   - ☐ **The following is the Rate per Session which I and my provider have agreed upon: $_______._______/ per telehealth session.** Notes:____
7. **I understand that,** same as it is with in-person services, **Financial Responsibility exists for paying for services exists when using Telehealth,** , regardless of whether it is thru EAP/ Insurance/ Self-Pay. **I am expected to pay at the time of service**.
8. I understand that **if my Insurance Denies a Claim** for telehealth **OR does not reimburse as much** as I anticipated, that it is **MY responsibility to communicate with MY Insurance company AND to share that information with my service**.
9. I agree to, **at the beginning of every Telehealth session, to inform the therapist of:**
   - **my actual physical location/address AND**
   - **who is present in immediate vicinity at that time**, not only for insurance reimbursement purposes, legal purposes, but **especially in case of a Mental Health Emergency/ Physical Health Emergency.**
10. I understand that mental health counselors are **prohibited** from providing telehealth services **when the client is not located in a state in which the counselor is licensed***. Therefore, **if I wish to engage in Telehealth services<u>, I will only do so when I am physically in the State of Tennessee at that time</u>**. (**Per current licensure rules in TN)(Erika B. Coppen, LPC-MHSP is only licensed in Tennessee*).
11. I understand that Cancellations need to be done thru the Secure Client Portal, and if I cannot do a session at the time that has been scheduled, it is my responsibility to **Communicate with my Provider (via: text (615)499-8636 /sending a Secure Message thru the Portal/ emailing: therapy@thrivemhs.com) AS SOON AS POSSIBLE, as to avoid paying unnecessary Fees.**

12. I understand there are potential risks to this technology, including interruptions of service due to cellphone/wifi signal problem, unauthorized access, and other possible technical difficulties.
13. **I understand that if,** for any reason **<u>I am unable to keep myself Safe</u>** (ex: due to Suicidal Ideation and unable to Contract for Safety) **OR I pose an immediate risk to someone else, that <u>I will need to seek immediate assistance and my therapist may choose to inform my Emergency Contact person or another person who can be effective</u>** (as is consistent with Legal Exceptions to Confidentiality). I understand that, while it will be ideal if I proactively seek that assistance myself (by for example seeking Assessment by a Psychiatric Hospital), I may need others to assist me to keep myself/others safe.
14. **I understand that there are specific situations which legally mandate action on my therapist's part and which are Legal Exceptions to Confidentiality**:
    - I am extremely Suicidal and I Cannot Contract for Safety;
    - I plan to Kill someone;
    - I have been Abused, are currently being Abused, or are at current risk of being Abused;
    - I know of someone who is currently being Abused or is at current risk of being Abused.
15. ***If I am a Parent of the Client, I understand that, for ages 10 and up, I must to make a concerted effort <u>to NOT overhear</u> (and prevent others from overhearing) the Content of my child's Telehealth Therapy Session**, so that my Child feels "Safe" to do their Therapy Work, similar to as it would be if performing face-to-face therapy.
16. I understand that if **I wish to include another party** (such as a child, my partner, spouse, etc.) **in the session as a "Guest"** (ex: in order to facilitate a conversation), that I have **separate Consent Paperwork that ☐ I and ☐ my Guest will need to complete.** That person is a Guest to help facilitate my growth and/or relationship, and is NOT the client. I am the Client. And no one else will be allowed into the session without my clear Consent.

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CONSENT TO USE THE "*TELEHEALTH BY SIMPLEPRACTICE*" SERVICE for outpatient psychotherapy:

"Telehealth by SimplePractice" is the technology service we will use to conduct telehealth videoconferencing appointments. **It is simple to use and there are no passwords required to log in. By signing this document, I acknowledge:**

1. In order to use *Telehealth by Simple Practice* I must **FIRST** either **download the *Telehealth by Simple Practice app* (available for use with android or apple devices) OR use my internet browser to open the secure single-use *Telehealth by Simple Practice weblink* (**sent to me via Email).

2. *Telehealth by SimplePractice* is **NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.**

3. Though my provider and I may be in direct, virtual contact through the Telehealth Service, neither *SimplePractice* NOR the Telehealth Service provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.

4. The *Telehealth by SimplePractice* service facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.

5. I do not assume that my provider has access to any or all of the technical information in the *Telehealth by SimplePractice* 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 *Telehealth by SimplePractice* service.

6. **To maintain confidentiality, I will NOT share my telehealth appointment link with anyone unauthorized to attend the appointment**.

By signing this form, I certify:

- **That I have read or had the above forms read and/or had these form explained to me.**
- **That I fully understand the contents of the above forms, 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.**

____ _____________________

Signature of Client **Date**

If this acknowledgment is signed by a personal representative on behalf of the client, complete the following:

Personal Representative's Name: ________________________________ **Relationship to Client:** __________________________

This form will be retained in the mental health record.

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- FOR OFFICE USE ONLY -

I attempted to obtain signed Acknowledgment of Receipt of Notice of Privacy Practices, but acknowledgment could not be obtained for the following reason:

☐ Individual refused to sign
☐ Communications barriers prohibited obtaining the acknowledgment
☐ An emergency situation prevented me from obtaining acknowledgment
☐ Other:____

Acknowledgement added to client's mental health record Date_______________ initials_____