Vann and Associates: Coaching, Counseling, and Consulting
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Informed Consent for Tele Mental Health Services

Client's Name:_____

The following information is provided to clients who are seeking Tele Mental Health therapy. This document covers your rights, risks and benefits associated with receiving services, Vann & Associates' policies and your authorization as a client or the guardian of a minor who will be participating in Tele Mental Health Services. Please review this document and contact your counselor or coach with any questions. If everything is agreeable, then please sign and return this document to your treatment provider. Therapy or coaching cannot proceed without a signed document.

Tele Mental Health Services Defined:

Tele Mental Health Services means the delivering of counseling or coaching services via technology-assisted media. The technology includes, but is not limited to, landline telephone, video, internet, a smartphone, tablet, IPad, laptop, PC desktop system or other electronic means. The delivery method must be secured by two-way encryption to be considered secure. Synchronous (at the same time) secure video chatting is the preferred method of service delivery.

Limitations of Tele Mental Health Therapy Services:

While Tele Mental Health Services offers several advantages such as convenience and flexibility, it is an alternative form of therapy or adjunct to therapy and thus may involve disadvantages and limitations. For example, there may 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. Primarily, there is a risk of misunderstanding one another when communication lacks visual or auditory cues. For instance, if video quality is lacking for some reason, the Counselor might not see various details such as facial expressions. Or if audio quality is lacking, the Counselor might not hear differences in the Client's tone of voice that could easily be picked up if Client were in the office.

Additionally, the therapy office decreases the likelihood of interruptions, such as people walking into the Client's room, conversations outside the door, pets in the home, children playing, etc. However, there are ways to minimize interruptions and maximize privacy and effectiveness. The Counselor will take every precaution to insure technologically secure and environmentally private psychotherapy sessions.

Finally, if there is a life-threatening emergency, the Counselor may be limited in how they may be able to assist the Client. Likewise, if the Client lives in the home with a potential perpetrator, confidentiality may be compromised if the perpetrator overhears the conversation.

Client Responsibilities for Tele Mental Health Services:

1. The Client will immediately notify the Counselor if they are uncomfortable with telephone or video counseling and has the right to terminate that mode of therapy.
2. The virtual counseling sessions can only be conducted while the client is within the state of Texas. Coaching clients may be in another state or country.
3. The live video sessions must be conducted on a Wi-Fi connection or hardwire internet for the best connections and to minimize disruption. The client is to test the speed of the connection prior to the video session.

4. It is strongly recommended that Clients only communicate through a device that they know is safe and technologically secure (e.g. has a firewall, anti-virus software installed, is password protected, possible VPN, etc.) Do not use "auto-remember" names and passwords.
5. Clients are not to access the internet through a public wireless network, social media platform, or gaming platform.
6. The Client is not to share any video counseling login information with other parties.
7. Clients who decide to use their school or work device for the visits need to verify their school or work's policy regarding use of such devices for personal communication and if the school or work will have access to that logon history or information.
8. The Client is to make sure that their technology settings do not allow for taping or automatic streaming of the session.
9. The Client is responsible for finding a private, quiet location where the sessions may be conducted via phone or video. **Sessions are not able to take place if other individuals are present in the Client's location without the express permission of the Counselor.**
10. Client and Counselor will develop a code word to be used if the Client feels unsafe in their environment.
11. Clients are encouraged to place a sign on the door to remind others in the office or house that the Client is not to be interrupted.
12. The Client agrees to be fully clothed during the video counseling session.
13. The Client agrees to be sober and alert.
14. The Client will agree to use earphones to minimize background noise and to help maintain confidentiality of the session.

Lack of compliance with any of these areas may be grounds to not proceed with Tele Mental Health Services.

Identity and Location:
The Counselor is required to verify the Client's identity and location at the start of each session.

In Case of Technology Failure:
Technology is not always the most consistent and interruptions do occur via the phone or video. Difficulties with hardware, software, equipment, and/or services supplied by a 3rd party may result in service interruptions. If something occurs to prevent or disrupt any scheduled appointment due to technical complications and the session cannot be completed via online video conferencing, please call your Counselor at the designated number that they have provided. The Client is to ensure that he or she has a phone with them during the video session in case of interruption and that the Counselor's phone number is programmed into it or the Client has access to the Counselor's business card.

Email and Texts:
Email and Text may compromise the Client's confidentiality. If the Client is experiencing a crisis, please do not communicate that need to the Counselor via email as that is not the most timely or efficient manner to communicate a pressing need. Instead, please see below under "Emergency Management Plan."

Interactive Video:
Doxy.me is being used for interactive video and phone calls which includes support 128-bit AES encryption for all signaling.

Credit Card Processing:
Stripe or Square are the companies that processes the Client's credit card information. The credit card holder will receive an email receipt by secure email indicating the credit card was used for said services, the date it was used and the amount that was charged. Additionally, please be aware that the transaction will appear on your credit card bill as Lori Vann LLC.

Emergency Management Plan:
If during the course of the phone or video session, the Counselor believes that that Client is in crisis and in need of a higher level of care due to safety concerns, the Counselor will notify the Client and their emergency person of said concerns and recommendations.
When calling or messaging, the Counselor can usually return a call or message within 24 hours unless they have informed the Client that they will be out of the office on business or personal reasons. If the Counselor is unavailable during a crisis or an emergency, it is imperative that the Client is aware of resources in their area. As a precaution, please identify two (2) nearby emergency hospitals below. In addition, the Client will need to provide information for an emergency contact person. These all must be completed to participate in Tele Mental Health services.

1. Hospital Name and City Location:_____
   Hospital Telephone Number: _____

2. Doctor/Hospital Name and Location: _____
   Hospital Telephone Number: _____

Emergency Contact Person: _____

Relationship: _____ Phone Number: _____

You may alternatively follow this plan:
1. Call Lifeline at (800) 273-8255 (National Crisis Line)
2. Call 911
3. Go to the emergency room of your choice
4. Contact your Psychiatrist

As the Client, I agree to take full responsibility for the security of any communications or treatment on my own computer, phone, or electronic device and in my own physical location. I understand I am solely responsible for maintaining the strict confidentiality of my user ID, password, and/or connectivity link. I shall not allow another person to use my user ID or connectivity link to access services. I also understand that I am responsible for using this technology in a secure and private location so that others cannot hear my conversations.

I understand that there will be no recording of any of the online sessions and that all information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without my written permission, except where disclosure is required by law.

Consent for Tele Mental Health Services Treatment:
As the Client or the legal guardian of said Client, I voluntarily agree to receive online or telephone therapy services for an assessment, continued care, treatment, or other services and authorize the Counselor 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 Vann 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.

I understand that my insurance may not cover the cost of telephone or video counseling and that I may have to pay the difference in whatever my insurance company does not pay the Counselor based on the Counselor's contracted rates.

Telephone and video sessions are only to be used during times of health outbreaks, such as COVID-19, national emergencies, natural disasters, or serious medical issues that inhibit the Client from attending in-person visits.

Informed Consent for Tele Mental Health Services

_____
Patient/Client Signature if 17 years of age or older

_____
Parent/Guardian/Legal Representative Signature *(if minor or needed otherwise)*

_____
Date

Format and Information for this form obtained from Dr. Rhonda Johnson and the Center for Counseling and Family Relationships in Fort Worth, 3/2020
Some modifications were made by Lori Vann, MA, LPCS