213 Terry Avenue., Crenshaw, MS 38621
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www.choicescreativetherapy.com
Jan Watson M.A. LPC

Informed Consent for Telemental Health Services

The following information is provided to clients who are seeking telemental health therapy. This document covers your rights, risks and benefits associated with receiving services, my policies, and your authorization. Please read this document carefully and note any questions you would like to discuss.

Client's Rights

- You have the right to decide to end our psychotherapy work at any time without prejudice.
- You have the right to ask any questions about procedures used during therapy. If you wish, I will explain my usual method of psychotherapy practices with you.
- You have the right to refuse the use of any therapeutic technique. I will inform you if I intend to use any unusual procedures and explain any risks involved
- You have the right to learn about alternative methods of treatment. I will discuss these with you during our work together.
- Telemental health services are not appropriate for all clients. Generally, those who are experiencing suicidal ideation or altered mental status are not appropriate. Should telemental health services not be a good fit for you I will assist you in finding alternative options.

Benefits and Risks

Telemental health refers to psychotherapy services that occur via phone, email, or synchronous video conferencing. When using technology there is always the risk of security issues, as well as technical issues (phone not charged, computer or software not working, etc.). You will need to develop an individualized plan for how best to address technical issues that may arise and will take steps to facilitate the security of

interactions with your therapist. In addition to the identified risks, there are several benefits that come from using technology. For instance, it allows therapist to connect with people who may otherwise not be able to access services, there is an opportunity for more flexibility in scheduling, and convenience in being able to connect from a space of your choosing. To protect your confidentiality and to facilitate the security of your information as much as possible, here is a list of recommendations:

- Engage in sessions in a private location where you cannot be heard by others
- Use a private phone
- Do not record any sessions
- Password protect any technology you will be interacting with your therapist on
- Always log out or hang up once sessions are complete

Emergency Management Plan

Choices Creative Therapy LLC, does not provide emergency services. You will be asked for your location at the start of each session. In the event of an emergency, it is imperative you are aware of resources in your area. As a precaution, please identify one (1) nearby emergency hospital below. In addition, you will need to provide information for an emergency contact person and agree that person can be contacted in case of an emergency. The following information must be filled out to participate in telemental health services.

Hospital #1 Name:_____

Hospital #1 Address:_____

Hospital #1 Phone:_____

Emergency Contact Name:_____

Emergency Contact Phone:_____

Contacting Your Therapist

Email is the main form of contact that will be used outside of the consultation and session. Every effort will be made to answer emails within 36 hours during the week. Emails are not regularly checked over weekends. Please note that email is not secure, so communication should be limited to scheduling questions, providing resources, and supplying any applicable insurance information.

Cancellation Policy

If you are unable to attend an appointment, it is requested that you provide at least 24 hours advanced notice to the office number (662-336-4411). Since I will be unable to use this time for another client, please note that you will be billed for the entire cost of your scheduled appointment if it is not timely cancelled, unless such cancellation is due to illness or an emergency. For cancellations made with less than 24-hour notice (unless due to illness or an emergency) or a scheduled appointment that is completely missed, you will be mailed a bill directly for the full session fee. Thank you for your help in keeping the office schedule running timely and efficiently.

Authorization for Treatment

I_____ have read and understand this Informed Consent form for Telemental Health Services provided by Choices Creative Therapy, LLC.

_____(Initials) I authorize evaluation and treatment from Jan Watson M.A. LPC, Choices Creative Therapy, LLC.

_____(Initials) I give my permission to Jan Watson M.A. LPC to contact the emergency contact person and/ or hospital that I have provided if an emergency arises.

_____(Initials) I acknowledge that I may request a copy of this informed consent agreement.

_____(Initials) It is agreed that either of us may discontinue treatment at any time.

Signature: _____Date:_____

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