**Telemental Health Informed Consent Form**

I\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[name of patient(s)] hereby consent to engaging in telemental health with Keisha Butler, LPC-S (LPC 19723)/ DeNette Vital, LPC-S (LPC 60854) as part of my psychotherapy. I understand that “telemental health” includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of mental health data, and education using interactive audio, video, or data communications. I understand that telemental health also involves the communication of my medical/mental information, both orally and visually, to health care practitioners located in Texas or outside of Texas.

I understand that I have the following rights with respect to telemental health:

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

(2) The laws that protect the confidentiality of my medical and mental health information also apply to telemental health. As such, I understand that the information disclosed by me during my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder and dependent adult abuse; expressed threats of violence towards self and/or an ascertainable victim; and where I make my mental or emotional state and issue in a legal proceeding.

(3) I understand that there are risks and consequences from telemental health, including, but not limited to the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical or mental health information could be disrupted or distorted by technical failures; the transmission of my medical or mental health information could be interrupted by unauthorized persons; the electronic storage of my medical information could be accessed by unauthorized persons; and/or limited ability to respond to emergencies.

In addition, I understand that telemental health-based services and care may not be as complete as face-to-face services. I also understand that my psychotherapist may provide virtual psychotherapy if my treatment needs determine that telemental health therapy services are appropriate. I understand that if my psychotherapist believes that I would be better served by another form of psychotherapeutic services (e.g. face-to-face services) I will be provided with that information and the rationale. I understand that my insurance company may or may not cover telemental health services. I understand that both myself and my psychotherapist are responsible for understanding my mental health benefits. I understand that I will be financially responsible for the full payment of my telemental health service in the event that my insurance does not cover that service. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not improve, and in some cases may even get worse.

(4) I understand that I may benefit from telemental health, but the results cannot be guaranteed or assured.

(5) I understand that I have a right to access my medical and mental health information and copies of medical records in accordance with Texas law.

**In Case of Technology Failure**

I understand that during a telemental health session there could be an encounter of a technological failure. 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 a scheduled appointment due to technical complications and the session cannot be completed via online video conferencing, I understand that I need to contact my psychotherapist Keisha Butler at: 214-298-7647 or DeNette Vital at: 469-658-5457. I understand that it is important for me to have my phone with me and that my psychotherapist has my phone number. I understand that I may also reschedule if there are problems with connectivity.

**Email**

Email is not a secure means of communication and may compromise your confidentiality. However, due to the current COVID-19 and the possibility of not being able to receive treatment resources in person, I agree to allow my psychotherapist to provide me treatment resources via email. If I do not want to receive treatment resources via email, I will inform my psychotherapist in writing.

**Cancellation Policy**

If I am unable to keep either a face-to-face or telemental health appointment, I understand that I must notify my psychotherapist or cancel online with at least a full 24-hour advanced notice from the time of my scheduled appointment. If such advance notice is not received, I understand that I will be financially responsible for the session that I missed. Please note that insurance companies do not reimburse for missed sessions.

**Emergency Management Plan**

If your psychotherapist is unavailable to see you in the event of a crisis, I understand that my psychotherapist will provide me with the contact information of a colleague. If the colleague or the psychotherapist are unavailable in the event of an emergency, I understand that it is imperative for me to be aware of the resources in my area. As a precaution, please identify two (2) nearby emergency hospitals below. In addition, you will need to provide information for an emergency contact person. I understand that all these resources must be completed to participate in telemental health services.

Hospital Name and Location:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospital Telephone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospital Name and Location:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospital Telephone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Person:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_TelephoneNumber:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

You may alternatively follow this plan:

Call Lifeline at (800) 273-8255 (National Crisis Line)

Call 911.

Go to the emergency room of your choice.

**I agree to take full responsibility for the security of any communication or treatment on my own computer 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 the services. I also understand that I am responsible for using this technology in a secure and private location so that others cannot hear my conversation.

**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.**

I consent to the use of the following forms of communication via technology:

\_\_\_\_ Texting

\_\_\_\_ Email

\_\_\_\_ Fax

I have read and understand the information provided above. I have discussed it with my psychotherapist, and all my questions have been answered to my satisfaction.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Client Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient, Guardian or Legal Representative Signature

(*if minor or needed otherwise)*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Psychotherapist Signature Date