**Tracy Brady Counseling**

SAN ANTONIO, TEXAS

Phone: 210-287-0424

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, note any questions you would like to discuss, sign and return.

**Effects of counseling:** At any time, you may initiate a discussion of possible positive or negative effects of entering, not entering, continuing, or discontinuing counseling. While benefits are expected from counseling, specific results are not guaranteed. Counseling is a process of personal exploration and may lead to major changes in your life perspectives and decisions. These changes may affect significant relationships, your job, and/or your understanding of yourself. Some of these life changes could be temporarily distressing. The exact nature of these changes cannot be predicted. Together we will work to achieve the best possible results for you.

**CLIENTS RIGHTS:** Some clients need only a few counseling sessions to achieve their goals; others may require months or even years of counseling. As a client, you are in complete control and may end our counseling relationship at any time. You also have the right to refuse or discuss modification of any of my counseling techniques or suggestions that you believe might be harmful. My counseling services will be rendered in a professional manner consistent with the current ethical practices promulgated by the Ethical Codes of the Texas State Board of Examiners of Licensed Professional Counseling, American Counseling Association, and the HIPAA security and privacy rules. If at any time for any reason you are dissatisfied with my services, please let me know so that existing issues can be worked through. If I am not available to resolve your concerns, you may report your complaints to the Texas State Board of Examiners of Licensed Professional Counselors at 1-800-942-5540.

**TeleMental Health Defined:** TeleMental health means the remote delivering of health care services via technology-assisted media. This includes a wide array of clinical services and various forms of technology. The technology includes but is not limited to, a telephone, video, internet, a smartphone, tablet, 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 TeleMental Health Therapy Services** : Until it is deemed safe to see clients physically in an office, I will contiunue to provide telemental health wherever possible. I have found that clients generally appreciate the flexibility and comfort of online sessions. While TeleMental health offers several advantages such as convenience and flexibility, it may have limitations. For example, there may be a disruption to the phone or internet service. If this occurs, I will try to reestablish the connection and we will proceed with your session as soon as we are both able.

**In Case of Technology Failure** :I understand that during a TeleMental health session we could encounter 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 any scheduled appointment due to technical complications and the session cannot be completed via online video conferencing, please call back at: 210-287-0424. Please make sure you have a phone with you, and I have that phone number. We may also reschedule if there are problems with connectivity.

Additionally, the therapy office decreases the likelihood of interruptions. However, there are ways to minimize interruptions and maximize privacy and effectiveness. Just as occurs in office, I will rely upon you to be as honest and forthcoming as possible in order to best help you. If I need to clarify what you say or an expression I see, I will ask. Please know that this is to ensure accuracy and not to be annoying or redundant. You can know that I will give you my best. As the therapist, I will take every precaution to insure technologically secure and environmentally private psychotherapy sessions. As the client, you are responsible for finding a private quite location where sessions may be conducted. Consider using a “do not disturb” sign/note on the door. The virtual sessions must be conducted on a wifi connection for the best connection and to minimize disruption.

**Structure and Cost of Sessions:** In return for your session fee I agree to provide counseling services for you. The fee for each session will be due at the end of each session. At this time I DO NOT accept credit/debit cards. Payment is expected at the time of service and cash, checks, Zelle and Venmo are all accepted forms of payment. Please note that Venmo is not HIPPA-compliant and you should consider making your payments to me “private” under “settings”.

**Email:** Email is not a secure means of communication and may compromise your confidentiality. However, I realize that many people prefer to email because it is a quick way to convey information. Nonetheless, please know that it is my policy to utilize this means of communication strictly for appointment confirmations and form delivery. **Please do not bring up any therapeutic content** via email to prevent compromising your confidentiality. I also strongly suggest that you only communicate through a device that you know is safe and technologically secure (e.g., has a firewall, anti-virus software installed, is password protected, not accessing the internet through a public wireless network, etc.). If you are in a crisis, please do not communicate this to me via email because I may not see it in a timely matter. Instead, please see below under "Emergency Management Plan”.

**Social Media - Facebook, Twitter, LinkedIn, Instagram, Pinterest, Etc**:  
If you choose to follow me on social media please do not reference our work together because it may compromise your confidentiality and blur the boundaries of our relationship. If this occurs I will block you from social media sites. Please only follow me if you are comfortable with the general public being aware of the fact that your name is attached to Tracy Brady, LPC, a known mental health care provider. Please refrain from making contact with me using social media messaging systems such as Facebook Messenger or Twitter. These methods have insufficient security, and I do not watch them closely. I would not want to miss an important message from you.

**Electronic Transfer of PHI:** Please read and sign the separate PHI form.

**Cancellation Policy:** In the event that you are unable to keep either a face-to-face appointment or a TeleMental health appointment, you must notify me at least 24 hours in advance. If such advance notice is not received, you will be financially responsible for the session you missed.

**REFERRALS:** You and/or I may believe that a referral is needed. In such cases, I will provide alternatives, including programs and/or other people who may be available to assist you. You will be responsible for contacting and evaluating those referrals and/or alternatives.

**RECORDS AND CONFIDENTIALITY:** All of our communications become part of the clinical record. Records are the property of Tracy Brady. In the event that I become incapacitated or at the time of my death, your records will be transferred to Kelsey Krueger in accordance with Texas LPC Ethical Codes. Most of our communication is confidential, but the following limitations and exceptions do exist, if:

*  You are in danger to yourself or someone else;
*  You disclose sexual contact with a mental health professional;
*  I am ordered by a court to disclose information;
*  You direct me to release your records;
*  I am otherwise required by law to disclose information;
*  There is a reason to believe that abuse or neglect of a child, elderly or disabled person has occurred or will likely occur.

To further protect your confidentiality, if I see you in public, I will only acknowledge you if you approach me first. In the case of marriage or family counseling, I will keep confidential (within the limits cited above) anything you disclose to me without your family member’s knowledge. However, I encourage open communication between family members, and I reserve the right to terminate our counseling relationship if I judge the secret to be detrimental to the therapeutic process

**Emergency Management Plan:** In theevent of a mental health crisis, Please call 911 and obtain emergency care. I am not an emergency provider and do not provide a 24-hour crisis counseling service. It isimperative you are aware of resources in your 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. This must be completed to participate in telemental health.

1.Hospital Name and Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

2. Hospital Name and Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TelephoneNumber:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

You may alternatively follow this plan:

1. Call 911

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

3. Go to the emergency room of your choice.

**I agree to take full responsibility for the security of any communications 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 session 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 to Treatment***

I, (Client signature) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_voluntarily agree to receive online therapy services for an assessment, continued care, treatment, or other services and authorize Tracy Brady, LPC 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 Tracy Brady, LPC 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.

Please use technology with discretion. Only communicate limited information such as appointment request, forms or cancellations.

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

* \_\_\_  Texting
* \_\_\_  Email
* \_\_\_  Document Sharing via text/email
* \_\_\_  Recommendations to Websites or Apps

By your signature below, you are indicating that you have read and understood this document, or that any questions you had about this document were answered to your satisfaction and that you were furnished a copy of this document., acknowledge your commitment to comply with all of its terms and requirements, issue consent for the Counselor to work with you and/or your child and acknowledge understanding and agreement with my financial obligations.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Client Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent, Guardian or Legal Representative Signature   *(if minor or needed otherwise)*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date

My signature below indicates that I have discussed this form with you and have answered any questions you have regarding this information.

Tracy Brady, LPC\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_