COUNSELING & PSYCHOLOGY SERVICES OF LAGRANGE, INC.

TELEMENTAL HEALTH
INFORMATION, AUTHORIZATION, AND CONSENT
FOR FAMILY VIOLENCE INTERVENTION PROGRAM (FVIP)

This document is designed to inform you about what you can expect from your clinicians regarding confidentiality, emergencies, and several other details regarding your treatment as it pertains to Tele-Mental Health or Tele-Psychology. Tele-Mental Health is a "subset of Telehealth, that uses technology to provide mental health services from a distance and includes telepsychology and tele-behavioral health and consultation. The mode of delivering services via technology-assisted media such as, but not limited to, a telephone, video, internet, a smartphone, tablet, personal computer (PC) desktop system or other electronic means using appropriate encryption technology for electronic health information. Tele-Mental Health facilitates client self-management and support for clients and includes synchronous interactions and asynchronous store and forward transfers" (American Telemedicine Association, 2009). We at Counseling & Psychology Services, Inc. (CPS) believe in your right to confidential mental health services and has policies and protective measures in place to assure your Private Health Information (PHI) remains confidential. It is important for you to know that landlines, text messaging, some email providers, social media, faxing are not confidential forms of communication.

CPS will utilize the confidential video services provided through Zoom for Healthcare format, for all Telehealth communication. As a client, it is your responsibility to make sure that you are using a secure device and that you are in a secure and private location to interact with Zoom and be aware that family, friends, and hackers could either overhear your communication or have access to the technology that you are interacting with. It is your responsibility to decide if you agree to use this form of communication.

The Zoom format should be available at no cost to you, and you should be able to download the app via Google Play or the iTunes App Store. You may discuss these options privately with your clinician. If at any time, you do not feel that Tele-Mental Health services is an appropriate service for you, please make your counselor aware and they will discuss alternatives with you.

Emergency Procedures Specific to Tele-Mental Health Services The following procedures, in the event of an emergency or crisis, are specific to Tele-Mental Health services:

1. You understand that if you are having suicidal or homicidal thoughts, experiencing psychotic symptoms (hallucinations, voices, or commands), or in a crisis that we cannot solve remotely, your clinician may determine that you are in need of a higher level of care and Tele-Mental Health services are not appropriate.

2. Please list below the name and contact information of an Emergency Contact that your clinician, only in the case of a life-threatening emergency, may reach out to.

Name: _____ Number: _____

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3. You agree to inform your clinician of the address where you are at the beginning of every Tele-Mental Health session.

4. You agree to be alone for your Tele-Mental Health sessions. If you are not able to be alone, you agree to tell your clinician at the beginning of the session. In case of Technology failure, the most reliable back up plan is to contact one another via telephone. Please make sure your clinician has that phone number.

5. You are responsible for the cost of any technology you may use at your own location. This includes your computer, cell phone, tablet, data plan, internet or phone charges, software, headset, etc.

Cancellation Policy: In the event that you are unable to keep your appointment, you must notify your clinician at least 24 hours in advance. If such advanced notice is not received, you will be financially responsible for the session you missed.

By signing this document, you are authorizing your clinician at Counseling & Psychology Services, Inc. to utilize the Zoom video format for your treatment, and you agree to comply with all other requirements, expectations, and standards set forth by the State of Georgia Commission on Family Violence. However, you may withdraw your authorization to use any of these services at any time during the course of your treatment via a written message (text, Zoom chat, email, etc.) to your counselor.

Please print, date, and sign your name below indication that you have read and understand the contents of this form, you agree to these policies, and that you are authorizing me to utilize the Tele-Mental Health methods discussed. *My signature below indicates that my clinician has discussed this form with me and has answered any questions I have regarding this information.*

Client Name (Please Print): _____

Client Signature & Date: _____

If Applicable: _____
Parent's or Legal Guardian's Name (Please Print)

_____
Parent's or Legal Guardian's Signature & Date