

Kara Goobic, Psy.D.  
Licensed Psychologist  
8720 Georgia Avenue  
Suite 205  
Silver Spring, MD 20910  
Phone: 240-242-9370  
Fax: 301-495-6394  
[drkaragoobic@gmail.com](mailto:drkaragoobic@gmail.com)

## **Client Information and Informed Consent for Telemental Health Treatment**

Telemental health services involve the use of electronic communications (telephone, written, text, email, video conference, etc.) to enable therapists to provide services to individuals who may otherwise not have adequate access to care.

Telemental health may be used for services such as individual, couples, or family therapy, follow-ups, and trainings/education in a group setting, as well as supervision and consultation on cases.

Telemental health is a relatively recent approach to delivering care and there are some limitations compared with seeing a therapist in person. These limitations can be addressed and are minor depending on the needs of the client and the care with which the technology (cell phone, computer, etc.) is utilized. It is important that both the client and the therapist are located in a private place during their sessions, and that the security of their technology be up-to-date with appropriate security protection.

Additional Points for Client Understanding:

- I understand that telemental health services are completely voluntary and that I can choose not to do it or not to answer questions at any time.
- I understand that none of the telemental health sessions will be recorded or photographed without my written permission.
- I understand that the laws that protect privacy and the confidentiality of client information also apply to telemental health, and that no information obtained in the use of telemental health that identifies me will be disclosed to other entities without my consent.
- I understand that because this is a technologically based method it may sometimes be necessary for a technician to assist with the equipment. Such technicians will keep any information confidential.
- I understand that telemental health is performed over a secure communication system that is almost impossible for anyone else to access, but because there is still a possibility of a breach, I accept the very rare risk that this could affect confidentiality.
- My therapist has explained to me how video conferencing technology and telephone procedures will be used. I understand that any telemental health sessions will not be exactly the same as an in-person session due to the fact that I will not be in the same room as my therapist.

- I understand there are potential risks to this technology and may include (but are not limited to): lack of reimbursement by your insurance company, the technology dropping due to internet connections, delays due to connections or other technologies, or a breach of information that is beyond our control. Clinical risks will be discussed in more detail with your clinician, but may include discomfort with virtual face-to-face versus in-person treatment, difficulties interpreting non-verbal communication, and importantly, limited access to immediate resources if risk of self-harm or harm to others becomes apparent. Your clinician will weight these advantages and will discuss the specifics of telehealth with you before using the technology.

\*I understand that I, or my therapist may discontinue the telemental sessions at any time if it is felt that the videoconferencing, text, email, or telephone connections are not adequate for the situation.

\* I understand that my demographic information may be shared with other individuals for scheduling and billing purposes.

\* I understand that I may experience benefits from the use of telemental health in my care, but that no results can be guaranteed or assured.

\* I understand that if there is an emergency during a telemental health session, then my therapist will call emergency services and my emergency contacts.

\* I understand that if the video conferencing or telephone connection drops while I am in a session, I will have an additional phone line available to contact my therapist, or I will make additional plans with my therapist ahead of time for re-contact.

\* I understand that I am required to provide a safety plan that is shared with my therapist in case of an emergency (see below).

\* I understand that telemental health-based services may not be appropriate for everyone seeking therapy. I also understand that if my therapist believes I would be better served by another form of therapeutic services (e.g. face-to-face services) I will be referred to a practitioner who can provide such services in my area.

\*I understand that this form is signed in addition to the Information, Authorization, and Consent to Treatment document and that all policies and procedures within the Information, Authorization, and Consent to Treatment document apply to telemental health services.

\* I understand I may be requested to install applications specific to treatment onto my phone, tablet or computer device. Some applications specifically interact via phone / tablet, device, etc. and have the capability to report activity, gps location, etc.

\* I understand I have the right to withhold or withdraw this consent at any time.

However, if I do so, this may require my therapist to provide referrals to other treatment providers if face-to-face services are not an option based on geography and/or circumstance.

\* I understand the laws that protect the confidentiality of my personal health information also apply to telemental health, as do the limitations to that confidentiality discussed in the Information, Authorization, and Consent to Treatment document. I also understand that the dissemination of any personally identifiable images or information from the telemental health interaction will not be shared without my written consent.

Consent: I consent to engaging in telemental health as part of my treatment with my therapist. I understand that “telemental health” includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of personal health information, and education using interactive audio, video, or data communications. I understand the information provided above regarding telemental health. I have discussed the consent with my therapist or assistant as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemental health in my care.

Signatures:

\_\_\_\_\_  
Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or legal guardian

\_\_\_\_\_  
Date

## Telemental Health Safety Plan Addendum

Client Name (first and last): \_\_\_\_\_

Physical Address of Client during telemental health sessions:

Street: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

(It is required that the client announce their location at each session when using videoconferencing, and it may be required that the client be at that same location for each session for the purposes of insurance payments.)

Client's Phone Number: \_\_\_\_\_

Alternative Phone Number: \_\_\_\_\_

Emergency Contact (1): \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_ City/State: \_\_\_\_\_

Emergency Contact (2): \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_ City/State: \_\_\_\_\_

Local Hospital (local to telemental health location of client): \_\_\_\_\_

Phone Number: \_\_\_\_\_

- I have provided two emergency contact numbers and the number to the local hospital or other facility as deemed appropriate.
- If there is an emergency during a session, my therapist has permission to contact my emergency contacts and the local hospital.
- I have provided a working telephone number to reach me if the video conferencing connection fails during a session.
- My therapist has provided me with a contact number. If connections fail and my counselor does not call me back within 5 minutes, then I will call my therapist.

Signatures:

\_\_\_\_\_  
Client

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Legal Guardian

\_\_\_\_\_  
Date

