



## *Tides of Mind Counseling*

### ***CONSENT FOR TELEMENTAL HEALTH SERVICES***

This form is to be used as a supplement to the signed Service Agreement and Treatment Consent Form that is required for all clients receiving services from Tides of Mind Counseling.

#### ***WHAT IS TELEMENTAL HEALTHCARE?***

Telemental health is a subset of telehealth services that uses online, interactive videoconferencing software to provide mental health services from a distance. Telemental health includes terms such as telepsychology, telebehavioral health, online counseling and distance counseling. Private insurance companies in Connecticut, New York and many other states are required by law to cover telemental health services. Telehealth does not include the use of fax, audio only (telephone), email or video telephony products such as FaceTime and Skype.

#### ***WHAT ARE THE POTENTIAL RISKS OF TELEMENTAL HEALTH?***

- Technological failures such as unclear video, loss of sound, poor internet connection or loss of internet connection.
- Nonverbal cues might be more difficult to observe and interpret during therapist and client interactions.
- May electronically share and sign practice and consent forms and accept risks that come with transmitting information and documents over the internet.

#### ***WHAT ARE THE BENEFITS OF TELEMENTAL HEALTH?***

- Less limited by geographical location and transportation concerns. Decrease in travel time and ability to meet virtually during inclement weather conditions.
- Ability to participate in treatment from your own home or other environment where you feel safe, secure and comfortable.
- Ability to participate in treatment from your home or other environment when physical needs/disabilities may prevent you from coming to the office.

#### ***ELIGIBILITY***

Tides of Mind Counseling and its clinical staff are only able to provide telemental health services to clients located in Connecticut where we hold valid licenses as mental health professionals. Clients must provide a valid ID or other proof of residency before telemental health treatment sessions can begin. A copy of this proof of residency will be kept in a client's electronic file.



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Telemental health may not be the most effective form of treatment for certain individuals or presenting problems. If it is believed the client would benefit from another form of service (e.g. face-to-face sessions) or another provider, an appropriate recommendation will be made.

### ***PRIVACY AND CONFIDENTIALITY***

The current laws that protect privacy and confidentiality also apply to telemental health services. Exceptions to confidentiality are described in the Notice of Privacy Practices. All existing laws regarding client access to mental health information and copies of mental health records apply.

Telemental health services are provided through the HIPAA compliant, secure software Doxy.me. No permanent video or voice recordings are kept from telemental health sessions. Clients may not record or store video conference sessions.

### ***CLIENT EXPECTATIONS DURING TELEMENTAL HEALTH SESSIONS***

You'll need the following to join a telemental health session with your clinician:

- A computer, tablet, or phone (no applications or software to download).
- An external or integrated webcam.
- An external or integrated microphone.
- An internet connection with a bandwidth of at least 10 MBPS. We recommend an Ethernet cable over Wifi when possible to ensure you receive the best possible connection through your internet provider.
- It may be helpful to shut down all background applications to ensure your telemental health session receives the majority of your internet's bandwidth, especially applications that use your camera.
- Access to Google Chrome, Mozilla Firefox or Safari (latest release versions) web browsers.
- Proper lighting and seating to ensure a clear image of each participant's face.
- Dress and environment appropriate to an in-office visit.
- Engage in sessions in a private location where you cannot be heard by others.
- Only agreed upon participants will be present and the presence of individuals unapproved by both parties will be cause for termination of the session.
- Client must disclose the physical address of their location at the start of the session. Unknown locations will be cause for termination of the session.



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- Client shall provide a phone number where they can be reached in the event of service disruption.

### ***EMERGENCY PROTOCOL***

Client is to provide the name and contact information for a local emergency contact. In the case of a mental health emergency during a telemental health session where a client is deemed at imminent risk of harming themselves or someone else, the therapist engaged in the session will contact the client's local emergency services and/or 911.

Release of information forms will be completed for necessary entities unless confidentiality must be breached to protect the safety of the client or other identified individual.

### ***INSURANCE, SELF-PAY RATES AND PAYMENT PROCEDURES***

Telemental health is not covered by all insurance companies, plans and policies. Currently, Anthem BC/BS is the only insurance company that Tides of Mind Counseling participates with that covers telemental health. Not all Anthem BC/BS plans/policies, however, cover telemental health for their customers. Tides of Mind Counseling will verify a client's Anthem BCBS policy prior to the first telemental health session and an email will be sent back to the client outlining these benefits and any out-of-pocket responsibility the client may have. Ultimately, it is the client's responsibility to be aware of and understand their specific plan and benefits.

Our self-pay rate for telemental health is the same as the in-session (face-to-face) rate of \$100/session. These sessions are 45-60 minutes in length. We have, however, added an additional service that includes a shorter 20-30 minute session (telemental health only) at \$75/session. The length of your specific session is set up between client and therapist prior to each session.

All clients must pay for telemental health services using a valid credit card. This credit card is placed on file in our electronic health record for security purposes. It is up to the client to notify Tides of Mind Counseling of any changes to their credit card information before a new telemental health session begins.



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### **CONSENT FOR TELEMENTAL HEALTH TREATMENT**

I hereby consent to engage in telemental health services with Tides of Mind Counseling and any member of its clinical staff. I understand that telemental health includes mental health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, and/or data communication of my medical and mental health information. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.

Printed Name of Client: \_\_\_\_\_

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name of Parent/Legal Guardian: \_\_\_\_\_

Parent/Legal Guardian Signature : \_\_\_\_\_ Date: \_\_\_\_\_

Printed Therapist Name: \_\_\_\_\_

Therapist Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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**Credit Card Authorization/ Billing Form**

Credit Card Type ( please check one)

- Visa
- Mastercard
- Amex
- Discover

- I authorize Tides of Mind Counseling to bill this credit card for any missed session fees incurred per policy during treatment.
- I also authorize Tides of Mind Counseling to:

- Bill this credit card for my co-payment/co-insurance and or deductible responsibilities and any out-of-pocket payments and/or denials not covered by my insurance.

Credit Card Number \_\_\_\_\_  
Exp: \_\_\_\_\_ 3 or 4 digit code \_\_\_\_\_

Name of Cardholder ( As it appears on the card):  
\_\_\_\_\_

Billing Address : \_\_\_\_\_  
City, State and Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_

I agree that my liability for this bill is not waived and I agree to be held personally liable in the event the indicated person, company or association fails to pay for any part or the full amount of these charges. I am an authorized user of the credit card and I will not dispute the payment with the credit card company so long as the transaction meets the terms of the authorization.

**Card Holder Signature:**

**Date:**

**Payment is due at the time services are rendered, and if done via telehealth ,will be charged at the end of the session.**