

**LULLWATER COUNSELING**  
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**INFORMED CONSENT TELEMENTAL HEALTH**

This is to be used in conjunction with, but does not replace, the Informed Consent document that is required of all clients prior to starting therapy services.

*What is Telemental Healthcare?*

Telemental healthcare includes the practice of diagnosis, treatment, education, goal setting, accountability, referral to resources, problem solving, skills training, and help with decision making through the use of internet-based videoconferencing, email, phone calls, or texting. Telehealth psychotherapy may include psychological health care delivery, consultation, coaching, and/or counseling. Telehealth psychotherapy will occur primarily through interactive audio, video, and telephone communications.

*Risks of Telemental Health*

1. Technological failure, such as unclear video, loss of sound, poor connection, or loss of connection.
2. Nonverbal cues are less readily available to both the therapist and the client.

*Benefits of Telemental Health*

1. Less limitations by geographical location.
2. Reduction of travel to a physical office, which includes decrease in travel time.
3. Participation in therapy from your own home or the environment of your choosing.

Telemental health delivery by Catherine Moon, LMSW may occur only with current residents of Georgia, unless allowed by the current resident's state laws. I, Catherine Moon, have the right to decline services to residents of other states. The current laws that protect privacy and confidentiality also apply to telemental health. Any exceptions to confidentiality are described in the Informed Consent document.

All existing laws regarding client access to mental health information and copies of mental health records apply. No permanent video or voice recordings are kept from telemental health sessions. Clients may not record or store videoconference sessions or face-to-face sessions.

*Expectations of client during each session*

1. Minimum bandwidth connection of 384 kb or higher.
2. Minimum resolution of 640x360 at 30 frames per second.
3. Operational web camera (HD 1080p is recommended).
4. Proper lighting and seating to ensure a clear image of each party's face.
5. Dress and environment appropriate to an in-office visit.

6. Only agreed upon participants will be present. The presence of any individuals unapproved by both parties and not part of the treatment plan will be cause for termination of the session.
7. The 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.
8. The client shall also provide a phone number where they can be reached in the event of service disruption.

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 referral will be made. If it would be beneficial for occasional face-to-face sessions with Catherine Moon, LMSW, this will be discussed as part of the treatment plan and the client has the right to refuse such a recommendation. This may result in a referral to another provider as well. All referrals will adhere to the Georgia State Board of Examiners Code of Ethics for Social Workers and the National Association of Social Workers.

#### *Emergency protocol*

Client is to provide the name and contact information for an additional person in case of emergency. In addition, in the event of a medical or mental crisis event in session, I will contact the client's local emergency services. The information provided will include the nature of the crisis and immediate needs of the client. Client is aware that Catherine Moon at Lullwater Counseling is a private practice and does not provide emergency services. In the event of a life threatening emergency, client agrees to call 911 immediately.

#### *Response to technical difficulties*

Should technical difficulties cause session disruption, Catherine Moon, LMSW will contact the client via preferred telephone contact. If the technical difficulties can be resolved quickly, the session will resume and the client will not experience a shortened session length. If the technical issues cannot be resolved in a timely manner, the session will be rescheduled for a time when functionality is restored. The client will be contacted by telephone to develop a plan for continuation of the session.

#### *Payment*

Session costs are outlined in the Informed Consent. Payment for services is to be made at, or prior to, the time of service via Square. See the Informed Consent for a more detailed discussion of session cost and payment.

#### *Contact between sessions*

Telephone contact, including texting, can be made in between sessions for the purposes of scheduling, DBT skills coaching, or other needs. If you need to speak with me via phone, please do not hesitate to contact me. If I am unavailable, please leave a voicemail. Usually, I return calls within the day.

Videoconference technology is reserved for therapy sessions only. Clients are aware they will be charged for text message exchanges or phone calls over ten minutes. I do not answer my phone after 10 P.M. or before 8 A.M. Clients are responsible for advising me if there is not a safe phone number or address to be

contacted, otherwise, I reserve the right to attempt contacting clients according to the information provided by the client on the intake form.

*Consent to Treatment*

I, \_\_\_\_\_, voluntarily agree to receive Telemental Healthcare assessment, care, treatment, or services and authorize Catherine Moon, LMSW 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 Catherine Moon 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.

\_\_\_\_\_  
Name of Client or Legal Representative

\_\_\_\_\_  
Relationship to client

\_\_\_\_\_  
Signature of Client or Legal Representative

\_\_\_\_\_  
Date

Please send a copy of the therapist-signed addendum to any of the following:

Address: \_\_\_\_\_

Email address: \_\_\_\_\_  
(only include email address if you are authorizing this as an acceptable means of communication)

Therapist: \_\_\_\_\_  
Catherine Moon, LCSW

\_\_\_\_\_  
Date