Safe Harbor Counseling
76 S Main ST., Ste A
Sugar Grove, IL 60554
Telemental Health Addendum

TELEMENTAL HEALTH: Telemental Health is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations.

I understand the following that

- I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.
- that there are risks and consequences associated with telemental health, including but not limited to,
    - disruption of transmission by technology failures,
    - interruption and/or breaches of confidentiality by unauthorized persons,
    - and/or limited ability to respond to emergencies.
- that there will be no recording of any kind of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.
- that the privacy laws that protect the confidentiality of my protected health information ("PHI") also apply to telemental health unless an exception to confidentiality applies.
- that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate and a higher level of care is required.
- that during a telemental health session, we could encounter technical difficulties resulting in service interruptions.
    - If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call your therapist at the phone number provided.

EMERGENCY PROTOCOLS: You agree to

- provide your location in case of an emergency to your therapist.
- inform your therapist of the address where you are at the beginning of each session.
- provide an emergency contact person who may be contacted in a life-threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

_____ Client initial

_____ Parent Initial

Safe Harbor Counseling
76 S Main ST., Ste A
Sugar Grove, IL 60554
Telemental Health Addendum

EMERGENCY CONTACT: ___________________________________

PHONE NUMBER: ___________________________________

CONFIDENTIALITY: The confidentiality of communication between a client and a therapist is very important and is protected by the ethical practices of the therapist as well as State and Federal Law. The Practice will make every effort to keep information regarding your evaluation, diagnosis, and treatment strictly confidential. A consent for release of information must be reviewed and signed by you in order for oral, written or electronic information about you to be released by the Practice to any other person or agency absent emergent circumstances.

All records or communications related to therapy are confidential and my confidences shall be maintained except as required by law, including, HIPAA and the Illinois Mental Health and Developmental Disabilities Confidentiality Act. These confidentiality laws and regulations do have exceptions which allow, and under certain circumstances, mandate that a therapist divulge information which is necessary to protect from imminent harm, emergency situations, child and elder abuse and the like. If you become involved in certain types of court proceedings wherein you have placed your mental health into issue in your claims or defenses, your records and information may be subject to disclosure in such a case.

COMMUNICATION: I authorize the Practice to communicate with me in the following ways: (Please Check & Initial)

☐ ☐_____Call / ☐ ☐_____ Leave a message - Cellular phone _______________________________

☐ ☐_____Call / ☐ ☐_____ Leave a message - Home phone _______________________________

☐ ☐_____Call / ☐ ☐_____ Leave a message - Office phone _______________________________

EMAIL AND TEXTING: Because email and texting are inherently insecure, these modes of communication are not allowed unless you specifically direct the Practice to utilize this mode of

_____ Client initial

_____ Parent Initial

communication. Please note that the regular use of email or texting is not HIPAA compliant and does not meet the ethical standards of therapists in the State of Illinois. Absent your specific direction to use these modes of communication, the Practice will only utilize them in cases of emergency. Please do not email or text content related to your therapy sessions. If you choose to communicate by email or text, there is no contemplation of privacy. While it is unlikely that anyone will see or acquire copies of any such communication, they are, by their nature, not secured.

☐ ☐ Communicate by Email: ____________________________

☐ ☐ Communicate by Text: ____________________________

I consent to the Telemental Health treatment of the above identified patient according to the terms outlined.

Patient name: ____

Birthdate: __________________

Patient/Parent/Legal Guardian name:

___________________________ _________________________________

Patient/Parent/Legal Guardian signature:

________________________ _________________________________

Date: __________________

_____ Client initial

_____ Parent Initial