Deb Elkin, LPC
2307 Desmond Drive
Decatur, Ga 30033
404-320-9548

DELIVERING SERVICES VIA TECHNOLOGY-ASSISTED MEDIA

TeleMental Health is the mode of delivering services via technology-assisted media, such as but not limited to, a telephone, video, internet, smartphone, tablet, PC desktop system or other electronic means using appropriate encryption technology for electronic health information.

TeleMental Health is a relatively new concept despite the fact that many therapists have been using technology assisted media for years. Breaches of confidentiality over the past decade have made it evident that Personal Health Information (PHI) as it relates to technology needs an extra level of protection. Additionally, there are several other factors that need to be considered regarding the delivery of TeleMental Health services in order to provide you with the highest level of care. Therefore, I have completed specialized training in TeleMental Health. I have also developed several policies and protective measures to assure your PHI remains confidential. These are discussed below.

THE DIFFERENT FORMS OF TECHNOLOGY-ASSISTED MEDIA EXPLAINED

Please initial after each section so that I know you have read and understand these descriptions.

Telephone via Landline:
It is important for you to know that even landline telephones may not be completely secure and confidential. There is a possibility that someone could overhear or even intercept your conversations with special technology. Individuals who have access to your telephone or your telephone bill may be able to determine who you have talked to, who initiated that call, and how long the conversation lasted. If you have a landline and you provided me with that phone number, I may contact you on this line from my own landline or from my cell phone. Typically this mode of communication will only be used to set up an appointment. If this is not an acceptable way to contact you, please let me know. Extended telephone conversations are billed at my hourly rate.
Initial: ________

Cell phones:
In addition to landlines, cell phones may not be completely secure or confidential. There is a possibility that someone could overhear or intercept your conversations. Be aware that individuals who have access to your cell phone or your cell phone bill may be able to see who you have talked to, who initiated that call, how long the conversation was, and where each party was located when that call occurred. I realize that most people have and utilize a cell phone. I may also use a cell phone to contact you, typically only regarding setting up an appointment. Extended cell phone conversations are billed at my hourly rate. Additionally, I keep your phone number in my cell phone, but it is listed by your first name and last initial only. My phone is password protected. If this is a problem, please let me know, and we will discuss our options.
Initial: ________

If we are on a phone session and we get disconnected, please call me back or contact me to schedule another session. If the issue is due to *my* phone service, and we are not able to reconnect, I will not charge you for that session.

Initial: ________

Text Messaging:

Text messaging is not a secure means of communication and may compromise your confidentiality. I realize that many people prefer to text because it is a quick way to convey information. Please know that it is my preference to utilize this means of communication strictly for appointment confirmations. I would prefer not to discuss any therapeutic content via text. If you do choose to text me and share more personal information, by initialing below, you are acknowledging you are aware that your confidentiality could be breached in doing this.

Initial: ________

Email:

Email is not a secure means of communication and may compromise your confidentiality. I realize that many people prefer to email because it is a quick way to convey information. Please know that it is my preference to utilize this means of communication strictly for appointment confirmations. I would prefer not to discuss any therapeutic content via email. If you do choose to email me and share more personal information, by initialing below, you are acknowledging you are aware that your confidentiality could be breached in doing this.

I also strongly suggest that you only communicate through a device that you know is safe and technologically secure (e.g., has a firewall, anti-virus software installed, is password protected, not accessing the internet through a public wireless network, etc.). If you do choose to contact me through an email, please be sure your email is password protected to ensure confidentiality.

Initial: _________

Social Media - Facebook, Twitter, LinkedIn, Instagram, Pinterest, Etc:

It is my policy not to accept "friend" or "connection" requests from any current or former client on my **personal** social networking sites such as Facebook, Twitter, Instagram, Pinterest, etc. because it may compromise your confidentiality and blur the boundaries of our relationship.

Initial: __________

Video Conferencing (VC):

Video Conferencing is an option for us to conduct remote sessions over the internet where we not only can speak to one another, but we may also see each other on a screen. I utilize Zoom Professional for these sessions. This VC platform is encrypted to the federal standard, HIPAA compatible, and has signed a HIPAA Business Associate Agreement (BAA). The BAA means that Zoom is willing to attest to HIPAA compliance and assumes responsibility for keeping our VC interaction secure and confidential. When we use this technology, I will send you a Zoom invitation the evening before our scheduled session.

Initial: __________

Recommendations to Websites or Applications (Apps):

During the course of our treatment, I may recommend that you visit certain websites for pertinent information or self-help. I may also recommend certain apps that could be of assistance to you and enhance your treatment. Please be aware that websites and apps may have tracking devices that allow automated software or other entities to know that you've visited these sites or applications. They may even utilize your information to attempt to sell you other products. Additionally, anyone who has access to the device you used to visit these sites/apps, may be able to see that you have been to these sites by viewing the history on your device. Therefore, it is your responsibility to decide if you would like this information as adjunct to your treatment or if you prefer that I do not make these recommendations.

Initial:____________

Credit Card Transactions:

I utilize Ivy Pay and Paypal as companies that processes your credit card information.They may send the credit card-holder a text or an email receipt indicating that you used that credit card for my services, the date you used it, and the amount that was charged. This notice has the potential to compromise your confidentiality. Please know that it is your responsibility to know if you or the credit card-holder has the automatic receipt notification set up. If you do not want an email or text receipt from me, it is your responsibility to inform me of this at the time of payment. Additionally, please be aware that the transaction will also appear on your credit-card bill.

Initial: ___________

Your Responsibilities for Confidentiality & TeleMental Health:

Please communicate only through devices that you know are secure as described above. It is also your responsibility to choose a secure location to interact with technology-assisted media and to be aware that family, friends, employers, co-workers, strangers, and hackers could either overhear your communications or have access to the technology that you are interacting with. Additionally, you agree not to record any TeleMental Health sessions.

Initial: __________

Emergency Procedures Specific to TeleMental Health Services:

There are additional procedures that we need to have in place specific to TeleMental Health services. These are for your safety in case of an emergency and are as follows:

You understand that if you are having suicidal or homicidal thoughts, experiencing psychotic symptoms, or in a crisis that we cannot solve remotely, I may determine that you need a higher level of care and TeleMental Health services are not appropriate.

I require an Emergency Contact Person (ECP) who I may contact on your behalf in a life-threatening emergency only. Please write this person's name and contact information below. Either you or I will verify that your ECP is willing and able to go to your location in the event of an emergency. Additionally, if either you, your ECP, or I determine necessary, the ECP agrees take you to a hospital. Your signature at the end of this document indicates that you understand I will only contact this individual in the extreme circumstances stated above. Please list your ECP here:

Name:____

Phone: ________________________

You agree to inform me of the nearest mental health hospital to your primary location that you prefer to go to in the event of a mental health emergency (usually located where you will typically be during a TeleMental Health session). Please list this hospital and contact number here:

Hospital:____

Phone: ________________________

Limitations of TeleMental Health Therapy Services:

TeleMental Health services should not be viewed as a complete substitute for therapy conducted in my office unless there are extreme circumstances that prevent you from attending therapy in person. It is an alternative form of therapy or adjunct therapy, and it involves limitations.

Primarily, there is a risk of misunderstanding one another when communication lacks visual or auditory cues. For example, when visual cues are absent (e.g. we can't see each other), I might not see a tear in your eye. Or, if audio quality is lacking, I might not hear the crack in your voice that I could easily pick up if you were in my office. There may also be a disruption to the service (e.g., phone gets cut off). This can be frustrating and interrupt the normal flow of personal interaction. Please know that I have the utmost respect and positive regard for you and your wellbeing. I would never do or say anything intentionally to hurt you in any way, and I strongly encourage you to let me know if something I've done or said has upset you. I invite you to keep our communication open at all times to reduce any possible harm.

Initial: __________

Consent to TeleMental Health Services:

Please check the TeleMental Health services you are authorizing me to utilize for your treatment or administrative purposes. Together, we will ultimately determine which modes of communication are best for you. However, you may withdraw your authorization to use any of these services at any time during the course of your treatment just by notifying me in writing. If you do not see an item discussed previously in this document listed for your authorization below, this is because it is built-in to my practice, and I will be utilizing that technology unless otherwise negotiated by you.

____Texting

____Email

___Phone sessions

___Recommendations to Websites or Apps

In summary, technology is constantly changing, and there are implications to all of the above that we may not realize at this time. Feel free to ask questions, and please know that I am open to any feelings or thoughts you have about these and other modalities of communication and treatment.

Please print, date, and sign your name below indicating that you have read and understand the contents of this form, that you agree to these policies, and that you are authorizing me to utilize the TeleMental Health methods discussed.

____ ________________

Client Name (Please Print) **Date**

____

Client Signature

My signature indicates that I have discussed this form with you and have answered any questions you have regarding this information.