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INFORMATION, AUTHORIZATION, & CONSENT TO TELEMENTAL HEALTH

You are given this document because you have requested TeleMental Health Services. This document is designed to inform you about what you can expect regarding confidentiality, emergencies, and other details regarding your treatment as it pertains to TeleMental Health. TeleMental Health is defined as follows:

> "TeleMental Health means the mode of delivering services via technology-assisted media, such as but not limited to, a telephone, video, internet, a smartphone, tablet, PC desktop system or other electronic means using appropriate encryption technology for electronic health information. TeleMental Health facilitates client self-management and support for clients and includes synchronous interactions and asynchronous store and forward transfers." (Georgia Code 135-11-.01)

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. There are several other factors that need to be considered regarding TeleMental Health services. You should know that I have completed specialized training in TeleMental Health. I have also developed several policies and protective measures to assure your PHI remains confidential which this form explains to you.

The Different Forms of Technology-Assisted Media Explained

Telephone via Landline and/or Cell Phone:
It is important for you to know that landline telephones and cell phones 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/cell phone, or your telephone/cell phone bill may be able to determine who you have talked to, who initiated that call, how long the conversation lasted, and where each party was located when that call occurred. If you have a landline and you provided me with that phone number, I may contact you on this line from my own landline in my office or from my cell phone, typically only regarding setting up an appointment if needed. If this is not an acceptable way to contact you, please let me know. Telephone conversations (other than just setting up appointments) are billed at my hourly rate. Additionally, I keep your phone number in my cell phone, but it is listed by your initials only and my phone is password protected. If this is a problem, please let me know, and we will discuss our options.

Text Messaging:
Text messaging is not a secure means of communication and may compromise your confidentiality. Furthermore, sometimes people misinterpret the meaning of a text message and/or the emotion behind it. As you know, I only use texting for scheduling and changing appointments. If you happen to send me a text message by accident, you need to know that I am required to keep a copy or summary of all texts as part of your clinical record that address anything related to therapy.

Email:
Email is not a secure means of communication and may compromise your confidentiality. However, I realize that many people prefer to email because it is a quick way to convey information. Nonetheless, please know that it is my policy to utilize this means of communication strictly for appointment confirmations. Please do not bring up any therapeutic content via email to prevent compromising your confidentiality. You also need to know that I am required to keep a copy or summary of all emails as part of your clinical record that address anything related to therapy.

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 are in a crisis, please do not communicate this to me via email because I may

Please initial that you have read this page: _____

not see it in a timely matter. Instead, please see below under "Emergency Procedures."

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.

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 Doxy.Me. This VC platform is encrypted to the federal standard, HIPAA compatible, and has signed a HIPAA Business Associate Agreement (BAA). The BAA means that Doxy.Me is willing to attest to HIPAA compliance and assumes responsibility for keeping our VC interaction secure and confidential. If we choose to utilize this technology, I will give you detailed directions regarding how to log-in securely. I also ask that you please sign on to the platform at least five minutes prior to your session time to ensure we get started promptly. Additionally, you are responsible for initiating the connection with me at the time of your appointment.

I strongly suggest that you only communicate through a computer or device that you know is safe (e.g., has a firewall, anti-virus software installed, is password protected, not accessing the internet through a public wireless network, etc.).

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. Please let me know by checking (or not checking) the appropriate box at the end of this document.

Electronic Transfer of PHI for Billing Purposes:
If I am credentialed with and a provider for your insurance, please know that I utilize a billing service who has access to your PHI. Your PHI will be securely transferred electronically to Office Ally. This billing company has signed a HIPAA Business Associate Agreement (BAA). The BAA ensures that they will maintain the confidentiality of your PHI in a HIPAA compatible secure format using point-to-point, federally approved encryption. Additionally, if your insurance provider is billed, you will generally receive correspondence from your insurance company, my billing company, or both.

Electronic Transfer of PHI for Certain Credit Card Transactions:
I utilize Converge as the company that processes your credit card information. Please know that it is your responsibility to know if you or the credit cardholder has the automatic receipt notification set up in order to maintain your confidentiality if you do not want a receipt sent via text or email. Additionally, please be aware that the transaction will also appear on your credit-card bill. The name on the charge will appear as Rachel Lacy, Psy.D., P.C.

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.

Communication Response Time

I'm required to make sure that you're aware that I'm located in the Southeast and I abide by Eastern Standard Time. My practice is considered to be an outpatient facility, and I am set up to accommodate individuals who are reasonably safe and resourceful. I do not carry a beeper nor am I available at all times. If at any time this does not feel like sufficient support, please inform me, and we can discuss additional resources or transfer your case to a therapist or clinic with 24-

Please initial that you have read this page: _____

hour availability. I will return phone calls within 24 hours. However, I do not return calls or emails on weekends or holidays. If you are having a mental health emergency and need immediate assistance, please follow the instructions below.

In Case of an Emergency

If you have a mental health emergency, I encourage you not to wait for communication back from me, but do one or more of the following:

· Call Behavioral Health Link/GCAL: 800-715-4225
· Call SummitRidge Hospital at 678-442-5858
· Call Ridgeview Institute at 770.434.4567
· Call Peachford Hospital at 770.454.5589
· Call Lifeline at (800) 273-8255 (National Crisis Line)
· Call 911.
· Go to the emergency room of your choice.

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 address where you are at the beginning of every TeleMental Health session.
- 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: _____

In Case of Technology Failure

During a TeleMental Health session, we could encounter a technological failure. The most reliable backup plan is to contact one another via telephone. Please make sure you have a phone with you, and I have that phone number. If we get disconnected from a video conferencing or chat session, end and restart the session. If we are unable to reconnect within ten minutes, please call me. 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.

Structure and Cost of Sessions

I may provide phone, and/or video conferencing if your treatment needs determine that TeleMental Health services are appropriate for you. If appropriate, you may engage in either face-to-face sessions, TeleMental Health, or both. We will discuss what is best for you. The structure and cost of TeleMental Health sessions are exactly the same as face-to-face sessions. I agree to provide TeleMental Health therapy for the fee of $150.00 for 55-60 minute sessions and $140.00 for 45 minute sessions. I require a credit card ahead of time for TeleMental Health therapy for ease of billing. Please sign the

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credit card authorization form on the last page so that I may charge your card without you being physically present. Your credit card will be charged at the conclusion of each TeleMental Health interaction. This includes any therapeutic interaction other than setting up appointments. Visa, MasterCard, Discover, or American Express are acceptable for payment, and I will provide you with a receipt of payment and the services that I provided. The receipt of payment & services completed may also be used as a statement for insurance if applicable to you (see below). Insurance companies have many rules and requirements specific to certain benefit plans. At the present time, many do not cover TeleMental Health services. Unless otherwise negotiated, it is your responsibility to find out your insurance company's policies and to file for insurance reimbursement for TeleMental Health services. As stated above, I will be glad to provide you with a statement for your insurance company and to assist you with any questions you may have in this area. You are also responsible for the cost of any technology you may use at your own location. This includes your computer, cell phone, tablet, internet or phone charges, software, headset, etc.

Cancellation Policy

In the event that you are unable to keep either a face-to-face appointment or a TeleMental Health appointment, you must notify me at least 24 hours in advance. If such advance notice is not received, you will be financially responsible for the session you missed. Please note that insurance companies do not reimburse for missed sessions.

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, if video quality is lacking for some reason, 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 or video drops). 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.

Face-to Face Requirement

If we agree that TeleMental Health services are the primary way we choose to conduct sessions, I require one face-to-face meeting at the onset of treatment. I prefer for this initial meeting to take place in my therapy office. If that is not possible, we can utilize video conferencing as described above. During this initial session, I will require you to show a valid picture ID and another form of identity verification such a credit card in your name. At this time, you will also choose a password, phrase, or number which you will use to identify yourself in all future sessions. This procedure prevents another person from posing as you.

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.

Email
Video Conferencing
Recommendations to Websites or Apps

Please initial that you have read this page: _____

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, you agree to these policies, and you are authorizing me to utilize the TeleMental Health methods discussed.

_____ _____

Client Name (Please Print) Date

_____

Client Signature

If Applicable:

_____ _____

Parent's or Legal Guardian's Name (Please Print) Date

_____

Parent's or Legal Guardian's Signature

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

_____ _____

Therapist's Signature Date

Please initial that you have read this page: _____

CREDIT CARD AUTHORIZATION

I authorize Rachel Lacy, Psy.D., P.C. to charge _____ (amount) to my credit card each month toward the balance for psychological services rendered for

_____
(Patient Name)

Two options for payment:

o I authorize that these charges be made on the _____ day of each month

OR

o I authorize the entire balance of _____ to be charged to my card upon receipt of this authorization form.

Credit Card Type: Visa Mastercard ATM/ Debit HSA

Card Number: _____ Expiration Date:_____

CVV (3 digit code on back of card):_____ Zip code of billing address:_____

Name as Appears on Card: _____

Note: If any third party payments are made resulting in a credit on your account balance, you will be reimbursed for overpayment.

By signing below, I am agreeing to billing the above charges to my credit card account. By signing below, I am stating that I understand that failure to provide consistent, monthly payments may result in my account being turned over to a collections agency and that the money owed would be reported to the credit bureau and be reflected on my credit history at that time. I also understand that I may be charged additional fees incurred for my account being turned over to a collections agency.

Authorized Signature: _____

Please initial that you have read this page: _____