

Magill Psychotherapy, LLC

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INFORMATION, AUTHORIZATION, & CONSENT TO TELEMENTAL HEALTH &/OR IN OFFICE SESSIONS

Thank you so much for choosing the services that I provide. Whether we meet in office or virtually please review this agreement. This document is designed to inform you about what you can expect from me regarding confidentiality, emergencies, and several other details regarding your treatment as it pertains to TeleMental Health or face to face sessions. Regardless of which you choose, there will be some level of TeleMental services provided. 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)

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

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 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.

Please initial that you have read this page: _____

Cell phones:

In addition to landlines, cell phones may not be completely secure or confidential. There is also 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. However, 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 if needed. Telephone conversations (other than just setting up appointments) are billed at my hourly rate. Additionally, I may keep your phone number in my cell phone, but it will only be 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. However, I realize that many people prefer to text 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 text to prevent compromising your confidentiality. You also 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. Even though we will only utilize email for appointments and brief topics, I also utilize a secure email platform that is hosted by [Hushmail](#) for your added protection, when necessary. I have chosen this technology because it is encrypted to the federal standard, HIPAA compatible, and the company has signed a HIPAA Business Associate Agreement (BAA). The BAA means that the company is willing to attest to HIPAA compliance and assume responsibility for keeping your PHI secure. [I encourage you to also utilize this software for protection on your end. Otherwise, when you reply to one of my emails, everything you write in addition to what I have written to you \(unless you remove it\) will no longer be secure. My encrypted email service only works to send information and does not govern what happens on your end.](#)

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

Please initial that you have this page: _____

Email (other than just setting up appointments) is billed at my hourly rate for the time I spend reading and responding to them. If you are in a crisis, please do not communicate this to me via email because I may not see it in a timely matter. Instead, please see below under "Emergency Procedures." Finally, you also need to know that I am required to keep a copy or summary of all email as part of your clinical record that address anything related to therapy.

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 www.VSee.com. This VC platform is encrypted to the federal standard, HIPAA compatible, and has signed a HIPAA Business Associate Agreement (BAA). The BAA means that **VSee** 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, here is the link to connect, <https://vsee.com/s/5e711cbd67016> I also ask that you please sign on to the platform five minutes prior to your session time to ensure we get started promptly. Additionally, unless otherwise agreed upon, you are responsible for initiating the connection with me at the time of your appointment. If you choose to use or need to use Zoom, that may be an option as well. We can discuss that as an option.

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 Record Storage: Your communications with me will become part of a clinical record of treatment, and it is referred to as Protected Health Information (PHI). Your PHI will be stored electronically with SimplePractice, a secure storage company who has signed a HIPAA Business Associate Agreement. Please initial that you have read this page: _____

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, your PHI may also be kept on my password protected computer in an encrypted file format.

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 [TransOrchid Consulting, LLC](#). 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 [Square or PayPal](#) as the company that processes your credit card information. This company 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 notification is usually set up two different ways - either upon your request at the time the card is run or automatically. Please know that it is your responsibility to know if you or the credit card- holder 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 [Magill Psychotherapy, LLC](#)

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-hour availability. I will return phone calls, texts or email within 24-72 hours. However, I do not return calls on weekends or holidays. If you are having a mental health emergency and need immediate assistance, please follow the instructions below.

Please initial that you have read this page: _____

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 Ridgeview Institute at 770.434.4567 or local hospital
- Call Peachford Hospital at 770.454.5589 or local hospital
- 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). For In-office sessions that hospital will be Piedmont Fayette or Piedmont Atlanta. 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.

Please initial that you have read this page: _____

If we are on a phone session and we get disconnected, I will call you 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 offer some face-to-face counseling. However, based on your ability to make in-person sessions and due to COVID-19, I may provide phone 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 described in my general "Agreement for Services" form. **Private Pay clients only:** I agree to provide TeleMental Health therapy for the fee of \$125.00 per 45-60 minute session and \$150 per 75 minute session. Texting and emails (other than just setting up appointments) are billed at my hourly rate for the time I spend reading and responding. I may require a credit card ahead of time for TeleMental Health therapy for ease of billing. Please sign the Credit Card Payment Form, which can be sent to you separately and indicates 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.** HSA cards, 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. You may also pay by check. Checks are to be made out to Magill Psychotherapy, LLC and mailed to 2011 Commerce Dr N Suite F109 Peachtree City GA 30269. 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, some 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 or in-office sessions. 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, a fee of \$50.00. Please note that insurance companies do not reimburse for missed sessions.

Please initial that you have read this page: _____

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 may require one face-to-face meeting at the onset of treatment as well as one face-to-face meeting every 3 months.** 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, we may 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.

- Video Conferencing
- Phone
- 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. If you decide to enter treatment by attending in office sessions, please follow all CDC guidelines pertaining to COVID-19. Masks are required upon entering and exiting the building. Once in office, masks are optional as there will be 6 foot distance between us. You're comfort and safety is my utmost concern, so please express what is most appropriate for you.

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: _____