

Kimberly Pillsbury, MA, LPC, LCADC, ACS, NCC, LLC

Psychotherapist

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CONSENT FOR TELEMENTAL HEALTH SERVICES

1. In light of COVID-19 precautions, my health care provider and I have mutually decided to engage in a telehealth consultation. Telemental health is a temporary service that is being offered due to extreme circumstances as a precautionary measure. When the crisis passes, therapy sessions will return to being in-person.
2. Video conferencing technology is not the same as a direct client/therapist visit due to the fact the therapist and client are not in the same room. Visual or auditory cues that are more apparent in-person may be missed in a video chat.
3. Confidentiality still applies for telehealth services, and nobody will record the session. However, you must make sure you are in a secure room where no one can hear your conversation and you can have minimal interruptions. Also, please use a secure internet connection rather than public/free Wi-Fi for your privacy.
4. As a counselor, I will also take every precaution to ensure technologically secure, HIPAA compliant, and environmentally private psychotherapy sessions. I cannot control the technology freezing, crashing or bad connections, but I will work with you every way we can to ensure the best possible interactions.
5. A webcam and audio will need to be enabled during the session. Headphones or earbuds may improve the sound quality and increase your privacy. Some clients may choose to sit in their car for the session for the utmost privacy.
6. I understand 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 (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding, physical health danger).
7. I understand that Telemental health is not a substitute for crisis/emergency services. In an emergency, dial 911 or go directly to your local emergency room.

8. I understand 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. I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.
9. I understand that a telehealth consultation has potential benefits including easier access to care, less potential exposure to COVID-19, and the convenience of meeting from a location in **New Jersey** of my choosing.
10. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation. This will not jeopardize my access to future care, services, and benefits.

IN CASE OF TECHNOLOGY FAILURE If service is disrupted due to a tech failure, please phone me at 732-737-1224. We may choose to reschedule if there are problems with connectivity.

STRUCTURE and COST OF THERAPY SESSIONS: Telemental health sessions are the same fees as face to face sessions. (\$130 per session). It is the understanding of the provider that Telemental health sessions during the current COVID-19 outbreak may be covered the same as in person session with your insurance company. Prior to any session, please verify insurance status and coverage. Please contact your insurance to verify coverage via Telemental health before engaging in it so you are clear about what the cost will be to you. Payment is the responsibility of the client or guardian regardless of insurance reimbursement and is due at time of service.

RELEASE OF LIABILITY: I unconditionally release and discharge Kimberly Pillsbury and Kimberly Pillsbury, LLC, from any liability in connection with my participation in the remote consultations. By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

BY SIGNING THIS DOCUMENT, I AM AGREEING THAT I READ AND UNDERSTOOD IT.

Signature

Date

Emergency Protocols:

I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf 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.

In case of an emergency, my location is:

and my emergency contact person's name, address, phone:

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

Signature of client/parent/legal guardian

Signature of therapist

Date

Date