

Chad J. Kelland, Psy.D., LCP/Kelland Psychological Services, LLC
Informed Consent for Telecounseling Services

Your signature below indicates you are aware of the following policies and procedures regarding patient confidentiality, informed consent, and consent for treatment via video technology for online psychotherapy by a Licensed Clinical Psychologist and notice of privacy practices. This is in conjunction with, but does not replace the initial informed consent document that is required of all patients prior to starting psychotherapy services. At your request, Dr. Kelland will provide you with a paper copy of the Notice of Privacy Practices. That notice contains your rights as a patient along with information on how your Protected Health Information (PHI) remains protected.

CONFIDENTIALITY/PRIVACY FOR TELEHEALTH TREATMENT:

Information disclosed to Dr. Kelland during session is strictly confidential. There will be no recording of any of the online sessions and all information disclosed within sessions along with any electronic notes and records pertaining to those sessions are private, confidential, and will not be released to any third party without written authorization, except where required or permitted by law. Exceptions to confidentiality include, but are not limited to:

- Reporting suspected child abuse, elder abuse, or dependent adult abuse.
- If the provider has knowledge or suspects that the patient may be a danger to themselves, to another person or property.
- If the patient is gravely disabled.
- If disclosure is court ordered.

DR. KELLAND'S RESPONSIBILITIES:

- Dr. Kelland will provide the HIPAA compliant telehealth care services (As of 3/23/2020 it will be DOXY.ME).
- Dr. Kelland will provide the link to access the telehealth care service and arrange for each appointment.
- Dr. Kelland will ensure sessions are conducted in a private and professional setting.
- Dr. Kelland will ensure that his office's internet connection is connected through secure, password protected technology.
- Dr. Kelland will not record sessions.
- Dr. Kelland will not share the telehealth care services link with anyone other than the patient(s) for a specific session.

PATIENT RESPONSIBILITIES:

- Patients accept full responsibility for the security of any communications or treatment on their own device and in their own physical location.
- Patients will not record session.
- Patients are encouraged to utilize an environment that is quiet, secure, and free from intrusion and distractions.
- Patients are encouraged to set aside time for scheduled sessions, take them seriously, and approach them with the same manner they would an in office visit.
- Patients are solely responsible for maintaining the strict confidentiality of their link for the session and will not allow another person to use their link to access telecounseling services.

_____ / _____ (Initials/Date)

POTENTIAL INTERRUPTIONS OF SERVICE:

Psychotherapy conducted online is technical in nature and problems may occasionally occur due to difficulties with hardware, software, equipment, and/or internet services supplied by a third party resulting in service interruptions. A preemptive plan will be discussed at the onset of tele-treatment in how to proceed if met with technical difficulties. If something occurs to prevent or disrupt any scheduled appointment due to technical complications and the session cannot be completed via online video conferencing, please send an email to drchadkelland@outlook.com or call 540.817.4375. Patients are discouraged from utilizing free/public WIFI to facilitate session.

TELEHEALTH CANCELLATION POLICY:

Should patient be **late to their appointment by fifteen (15) minutes or more, Dr. Kelland reserves the right to cancel and reschedule the appointment.**

In the event that Dr. Kelland determines that telecounseling is no longer appropriate, Dr. Kelland will discuss with patient additional treatment options will be reviewed and offered, including community referrals.

HOURS/EMERGENCY SERVICES/CRISIS SITUATIONS:

Telecounseling is not a 24-hour service. Dr. Kelland will adhere to providing telecounseling services during his normal office hours and by appointment only.

1. I agree that **certain situations**, including **emergencies and mental health crises**, are **inappropriate** for audio/video/computer based counseling services. These include:

- Thoughts of hurting or killing myself or another person;
- Hallucinations; delusions; or psychosis;
- Being in a life threatening emergency of any kind; and/or
- Being under the influence of alcohol or drugs.

(____/____ Initial and Date)

2. I understand that Dr. Kelland may not be available for contact between scheduled sessions. If I am in an emergency or crisis situation (such as those listed above), I should call 911 immediately or seek help from a hospital or crisis-oriented health care facility in my immediate area. If I am experiencing thoughts of suicide **without** a clear commitment to safety, I am to contact one of the following resources:

- Call 911
- National Suicide Prevention Lifeline: 1-800-273-8255
- Crisis Text Line: Text HOME to 741741

(____/____ Initial and Date)

PERMISSION TO TREAT: I, the undersigned patient and/or legal guardian, authorize telecounseling services/treatment by Dr. Kelland. I have been given an opportunity to ask any question related to my treatment and this form. I have read, understand and agree to all of the above.

Print Name

Birth Date

Telephone Number

Signature

Date

Legal Guardian Name (if patient is a minor)

Legal Guardian Signature (if student is a minor)

Witness