OLNEY
Counseling Center, LLC
Providing help and hope for those in need.

3300 Olney Sandy Spring Rd, Suite 340
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(301)570-7500 Fax (301)570-7504

Tele-therapy Services Through OCC

Tele-therapy with OCC: the delivery of therapeutic services by which the therapist and client are not within the same physical location. This includes, but is not limited to, Web Cam sessions, Telephone conversations, E-Mails, Text Messages, or any communication involving the Internet or phone as a medium. Tele therapy can be offered on weekends and evenings as scheduled or as needed. Scheduling is flexible and can be arranged between client and therapist.

Must meet agency requirements which include:

- Low risk meaning: No Self harming, Suicidal or Homicidal thoughts or behavioral, or high-risk diagnosis.
- Initial/Intake appointment must take place in the office during regular business hours
- Must be approved by lead Therapist/Owner/Supervisor after initial intake session is reviewed.
- Patient and Guardian must meet therapist for an In-person/face to face therapy session every three months or as recommended by therapist. The guardian being present is to ensure a full picture of the client's functioning is provided to the therapist at the in-person session and as a reminder that the parents/care taker plays a pivotal role in the effectiveness of treatment.
- Therapist must have a release to call an adult and or guardian in case of emergency or safety risk.
- Tele-therapy can be denied at any time if the client has an increase in risks or concerns for safety. At this time client can meet in person for a designated period or the therapist can provide names/contact information of agencies that may be able to meet the client's therapeutic needs.
- Tele-therapy can be denied at any time if the client has an outstanding open balance. All tele-therapy must be paid for in advance at time of therapy, no exceptions.
- Client's case will be reviewed yearly for continued approval for tele-therapy
- If at any time a therapist feels a client is a danger to themselves or others it they may call the police for an onsite well check or emergency petition for a hospital evaluation.
- Tele-therapy can only be provided in the State of Maryland.

Cancelations: It is expected that you be on time for your appointment and provide 24 hours' notice for cancelations. **If 24 hours' notice is not provided it will result in a missed appointment fee that is in accordance with the missed appointment rate charged by OCC of $100.00.** This policy is in place to give Clinicians adequate time to fill appointment time slots for clients in need of mental health attention and support and provide partial compensation to your therapist.

If the clinician must cancel your appointment, they will give you as much advanced notice as possible and reschedule as soon as possible.

_____(initials) Client, Parent, or Managing Conservator **I have read this Consent for Treatment and I understand it fully, and voluntarily sign**

A Note about Confidentiality

Everything that is discussed and disclosed in session is confidential, but there are limits to this.

- If at any time it is assessed that a client is at risk of hurting others in any way the clinician has a duty to warn the authorities and person that may be in harm's way.
- If at any time it is assessed that a client is at risk of harming themselves or at risk for suicide the clinician has a duty to keep you safe, which means the clinician can emergency petition for a client to be evaluated by a hospital/ER.
- Child abuse and neglect. In cases of child abuse which includes: physical, sexual, and emotional abuse as well as neglect therapist are mandated reporters which means by law the clinician must report this information to the CPS agency of the county the abuse occurred. The clinician is also mandated to report previous occurrences of abuse in adult survivors.

In the case that a report is to be made the clinician will do their best to review with the client how this process works and what you are to expect during this process, but this is not always guaranteed especially in cases when a minor has disclosed suspected abuse.

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Tele therapy should not be confused with face to face therapy, as it has the following restrictions: it is possible a 3rd party within your environment, or the therapist's environment, to overhear the conversations being conducted. In addition, a 3rd party could hack (man in the middle attack) and overhear or see the session as it is being conducted. Any documents or text messages could be obtained by a 3rd party. Viruses, Trojans, Worms, and other programs could reside on clients of therapist's computers which could send private information to a 3rd party. Due to these risks, it is important to maintain appropriate security measures. Firewalls, up to date virus scanners, and patched computer systems will help reduce the likelihood of a data breach, however no method is 100% secure.

By signing this form, you, the client, acknowledge these risks.

It is the responsibility of the client to provide their own equipment in order to conduct the tele therapy session. This includes a computer or tablet, a webcam or camera built into their device, and Internet access to conduct the session. It is the therapist's responsibility to provide similar equipment in their environment.

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It is the responsibility of the client to make sure the environment chosen to conduct the tele therapy session is as private as possible. In this environment, it is the client's responsibility to keep distractions to a minimum. In addition, it is the responsibility of the client to protect confidential information within their own environment (prevent anyone from listening in to the session from someone else in the home). It is the therapist's responsibility to do the same in his environment.

Tele therapy does not provide emergency services. If you are experiencing an emergency, call 911 or proceed to the nearest hospital emergency room for help, or contact your psychiatrist. If you are having suicidal thoughts, contact the National Suicide Prevention Lifeline at: 1-800-273-8255.

As in face to face therapy, there are no guarantees to the improvement of any condition while in the practice of psychotherapy, including the use of tele therapy. Some conditions may not improve, or even get worse. By signing this form you agree to this possibility.

1. I understand that my health care provider wishes me to engage in a telemedicine consultation.
2. My health care provider has explained to me how the video conferencing technology will be used to affect such a consultation will not be the same as a direct patient/health care provider visit because I will not be in the same room as my health care provider.
3. 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 telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my health care provider and consulting health care provider in order to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room: and or (3) terminate the consultation at any time.
5. I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a telemedicine consultation. I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting health care provider.
6. In an emergent consultation, I understand that the responsibility of the telemedicine consulting specialist is to advise my local practitioner and that the specialist's responsibility will conclude upon the termination of the video conference connection.
7. I understand that billing will occur from both my practitioner and as a facility fee from the site from which I am presented.
8. I have had a direct conversation with my doctor, 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.

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Signing acknowledges you have received, understand, and agreed to this Client-Clinician Agreement for tele therapy services.
By signing this form, **I have read this Consent for Treatment and I understand it fully, and voluntarily sign**:

_____(initials) That I have read or had this form read and/or had this form explained to me
_____(initials) That I fully understand its contents including the risks and benefits of the procedure(s).
_____(initials) That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Patient Name: _____ DOB_____

_____ Date: _____

Client, Parent, or Managing Conservator

Clinician's Signature of Approval for Tele-Therapy: _____

Manager Signature of Approval for Tele-Therapy:_____