



## **TECHNOLOGY ASSISTED COUNSELING (TAC) CONSENT, POLICIES, & AGREEMENT**

This form is in **addition** to the regular Therapy, Policies, Agreement and Consent Form and Notice of Privacy Practices for Protected Health Information commonly known as HIPAA. You must sign both in order to participate in Technology Assisted Counseling (TAC) sessions. TAC incorporates email, phone and video counseling. Prior to engage in TAC an assessment/consultation will be done to assure that TAC is an appropriate form of counseling. This is to inform you about what you can expect regarding your participation in TAC counseling.

### ***Benefits:***

The benefits to TAC counseling are:

1. The ability to expand your choice of service provider.
2. More convenient counseling options including location, time, no driving, etc.
3. Reduces the overall cost and time of therapy due to not having to drive to and from and office.
4. Ability to have real time monitoring and reduces the wait time for scheduling office appointments.
5. Increased availability of services to homebound clients. clients with limited mobility, and clients without convenient transportation options.

### ***Limitations:***

It is important to note that there are limitations to TAC counseling that can affect the quality of the session(s). These limitations include but are not limited to the following:

1. I cannot see you, your body language, or your non-verbal reactions to what we are discussing.
2. Due to technology limitations I may not hear all of what you are saying and may need to ask you to repeat things.
3. Technology might fail before or during the TAC counseling session.
4. Although every effort is made to reduce confidentiality breaches, breaches may occur for various reasons.
5. To reduce the effect of these limitations, I may ask you to describe how you are feeling, thinking, and/or acting in more detail than I would during a face-to-face session. You may also feel that you need to describe your feelings, thoughts, and/or actions in more detail than you would during a face-to-face session.

### ***Logistics:***

When I provide phone/video-counseling sessions, I will call you at our scheduled time or send you a link for our secure and HIPAA compliant video session. I expect that you are available at our scheduled time and are prepared, focused and engaged in the session. I



***Recording of Sessions:***

Please note that recording, screenshots, etc. of any kind of any session is not permitted and are grounds for termination of the client-therapist relationship.

***Payment for Services:***

Payments for services must be made **prior** to each session. I will charge your card on file. Payment is to be completed prior to our session.

***Cancellation Policy:***

If you must cancel or reschedule an appointment, 24-hour advance notice is required, otherwise you will be held financially responsible. Should you cancel or miss an appointment with notification less than 24 hours this will result in being charged the \$50 fee for your missed appointment. Cancellations must be communicated by phone, NOT email or text. If clients have more than 2 cancellations during the course of treatment/therapy the therapist and client will address the need for ongoing therapy. Should a client express and wish and/or desire to continue a client may be asked to pre-pay for sessions when they are scheduled. If the client cancels or misses the session with less than 24 hours notice and the session is pre-paid, this follows the cancellation guidelines and the payment will not be reimbursed for the missed or canceled session less than 24 hours. Phone/video sessions should be treated as regular in office sessions. If you are late getting on the phone, are unable to talk at our scheduled time, your battery has died and you are unable to access another confidential place to talk, or any other variable that would have you not be able to attend our session please know that you will be charged for the session. Please make the necessary arrangements you need to be available and present for your session.

***Emergencies and Confidentiality:***

I request an emergency contact for you. Please list the person's first and last name, relationship and phone number(s) of your emergency contact:

---

Full Name	Relationship	Number(s)
-----------	--------------	-----------

I also request the address from which you are calling and the number to your local police department including area code in the area in which you are located during the time of our call.

---

Street Address

---

City Code	State	Zip
-----------	-------	-----



---

City and State of Local Police Department

Phone Number

If a situation occurs where we are talking and get disconnected and you are in crisis, you agree to call 911, go to your local emergency room immediately or contact the National Suicide Hotline at 800-784-2433.

If I have concerns about your safety at *any* time during a phone session, I will need to break confidentiality and call 911 (if located in the same county or emergency services in the area you are located at the time of the call) and/or your emergency contact immediately. Please note that everything in our informed consent that you signed, including all the confidentiality exceptions, still applies during phone/video sessions.

***Consent to Participate in TAC Sessions:***

By signing below you agree that you have read and understand all of the above sections of TAC informed consent. You agree that you also understand the limitations associated with participating in TAC counseling sessions and consent to attend sessions under the terms described in this document.

Client's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Client's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Client's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Client's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Clinician's Signature/Credentials: \_\_\_\_\_ Date: \_\_\_\_\_