Lighthouse Counseling Center

121 Jackson Street
Newnan, GA 30263
Phone:(770) 251-5873 Fax:(770)304-2201

INFORMED CONSENT FOR TELEPSYCHOLOGICAL SERVICES

Prior to starting video-conferencing services, we discussed and agreed to the following:

- There are potential benefits and risks of video-conferencing that differ from in-person sessions. Video Conferencing is an option for your therapist to conduct remote sessions with you over the internet where you may speak to one another as well as see one another on a screen. We utilize Doxy.me. This VC platform is encrypted to the federal standard, HIPAA compatible, and has signed a HIPAA Business Associate Agreement (BAA). The BAA means that Doxy.me is willing to attest to HIPAA compliance and assumes responsibility for keeping your VC interaction secure and confidential. If you and your therapist choose to utilize this technology, your therapist will give you detailed directions regarding how to log-in securely.
- Confidentiality still applies for telepsychology services, and nobody will record the sessions without the permission from the others person(s).
- We agree to use the video-conferencing platform selected for our virtual sessions, and the psychologist will explain how to use it.
- You need to use a webcam or smartphone during the session.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- It is important to be on time. If you need to cancel or change your tele-appointment, you must notify the psychologist in advance by phone.
- We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.
  Number______________________________
- We need a safety plan that includes at least one emergency contact and the closest ER to your location, in the event of a crisis situation.
- We need the permission of your parent or legal guardian (and their contact information) for you to participate in telepsychology sessions.
- You should confirm with your insurance company that the video sessions will be reimbursed; if they are not reimbursed, you are responsible for full payment.
- As your therapist, I may determine that due to certain circumstances, telepsychology is no longer appropriate and that we should resume our sessions in -person.

Psychologist Name/Signature:______________________________________

Patient Name:____

Signature of Patient/Parent/or Legal Guardian:__________________________

Date:____

In Case of an Emergency:

If you have a mental health emergency, we encourage you not to wait for communication back from your therapist, but do one or more of the following:

- ***Call Behavioral Health Ling/GCAL: 800-715-4225***
- ***Call Ridgeview Institute at 770-434-4567 or Piedmont Newnan Hospital at 770-400-1000***
- ***Call Peachford Hospital at 770-454-5589 or Piedmont Newnan Hospital at 770-400-1000***
- ***Call Lifeline at 800-273-8255 (National Crisis Line)***
- ***Call 911***
- ***Go to the emergency room of your choice.***

Lighthouse Counseling Center, PC (LHCC)
121 Jackson Street
Newnan, GA 30263

CREDIT / DEBIT CARD PAYMENT FOR PROFESSIONAL SERVICES

____ VISA ____ MasterCard ____ AMEX ____Discover

Name as it appears on card ____

Credit / Debit Card Number __________ - __________ - __________ - __________

Billing Zip Code ____________________

Exp. Date ______/__________

I/we authorize LHCC, to bill the above credit / debit card for professional services to as outlined in the policies. I also authorize LHCC to charge the above credit card for telehealth sessions/telephone sessions. I will notify LHCC in writing if I no longer want my credit / debit card billed.

____ - ___________________________
Signature of cardholder Date

____
Client (s) name