CLIENT INFORMED CONSENT FORM

Informed consent for video/audio consultation with Clinical Psychologist for psychotherapy at Home of Beautiful Souls.

General Information provided to me.

About Psychotherapy:

Psychotherapy is a way to help people experiencing significant emotional distress that is coming in the form of them being physically well, enjoying personal relationships, or working productively. Psychotherapy begins with the therapist understanding the person's background seeking help2 and the concerns that led them to seek help. Following this, the client and psychotherapist agree on treatment goals, treatment procedures, and a regular schedule for the time, place, and duration of their treatment sessions.

About Tele-psychotherapy:

Tele-psychotherapy refers to providing psychotherapy services using telecommunication technologies, including email, text messaging, video conferencing, online
chat, messaging, or internet phone. Tele-psychotherapy would typically involve all aspects of psychotherapy, except that it would be offered using telecommunication technologies.

What I have understood about Tele-psychotherapy Services

Possible limitations to care:

I understand that video/audio consultation has its limitations compared to in-person sessions, and some details could be missed despite the psychotherapist's best efforts. I understand that tele-psychotherapy services are by appointment only and that these consultations are not suitable for help during a crisis or emergency. I understand that the psychotherapist contacted during a set appointment would evaluate my need and context and guide me about the most suitable option for psychological intervention in that context (tele-psychotherapy/ in-person psychotherapy/ crisis intervention/ emergency services).

Responsibility for adverse events:

I understand that the psychotherapist would use their professional discretion to provide required recommendations about the type of professional service required at any given point in time. At the same time, I agree not to hold my psychotherapist responsible should any adverse events, such as lack of improvement, deterioration, or situations of the potential risk of harm to self or others, occur during video/ audio consultation. I understand that I may be advised to obtain treatment at the nearest available mental health or emergency service in such situations.

Confidentiality and Recording:

I understand that this audio/ video consultation is strictly confidential. I agree to use a secure line/ connection for these consultations in a relatively quiet and private space. I understand that my psychotherapist will not use audio or video to record the session (either on mobile, using an app, or online) and will not share the proceedings of this consultation with any other individual or agency. However, with my consent, my psychotherapist could use it to have their work supervised or for the training of professionals. Apart from this, the consultation details would be shared only with a court of law if mandated.

Notes of the tele-psychotherapy consultation will be maintained by my psychotherapist and stored in a safe location. I understand that these session notes can be made available to me, in the standard session record format, on my explicit request.

I also undertake that the proceedings of these consultations are not to be recorded, shared, or disseminated by me or my relatives / other contacts to any third person or through social media. However, despite safety measures taken, there are chances for breaches in security in technology. In such instances, both the client and psychotherapist will not hold the other responsible for the violation.

Payment and Billing:

I understand that these consultations will be charged at the same rate as in-person sessions or at a lower rate than discussed before beginning sessions. The timing and mode of payment will be discussed with me. I understand that my consent expressed online would suffice for me to receive tele-psychotherapy services.

I understand that my psychotherapist will discuss the tele and audio options available and suitable and that we will decide on what to use, considering my preference and the suitability of a choice as assessed by my psychotherapist. I understand that if there are any communication difficulties (technical) during the session, it will be terminated, and a new appointment will be scheduled. I understand that I have the freedom to withdraw from these sessions at any time if I wish. I understand that my therapist may also temporarily stop or discontinue these audio/video sessions/recommend any other method or line of treatment if either of us experiences any difficulty in the process and in my best interest.

Consent:

I hereby provide my informed consent for video/audio consultations for tele-psychotherapy at

_____

(insert Name of the Professional/Organization/Unit providing the Service).

GUIDELINES

1. **Dual relationship**: During our entire therapy process, there will not be any other relationship, e.g., friendship. This will ensure that the professional role remains clear.
2. **Time and duration**: The time and duration of the session will be decided in advance, collaboratively. Cancellation of the session by the client or therapist will require a 24-hour prior notice. Once a month, the emergency will be accepted; otherwise, the client will be charged for the session or fined accordingly.
3. **Frequency of Sessions**: The frequency of the sessions will depend on the client's needs and the therapist's understanding of the condition. The total duration will be provided after the initial sessions of therapy. Note: It may vary based on the client's progress.
4. **Emergency**: In case of emergencies, the therapist will be given 30 minutes to respond. If the therapist is unable to respond, kindly contact emergency services nearby. If the client is at risk of harming themself or others, a family member will be informed about the client's acute condition to protect the client. (refer to 'Exceptions to Confidentiality')
5. **Termination of therapy**: If the client wishes to end treatment before the decided tenure, due to financial or variable constraints, the client will have to inform the therapist about the same. A plan will be worked to safeguard the client's condition

from worsening. Incase therapy is not helping the client or worsening symptoms; the therapist can choose to terminate treatment or suggest better means to improve.

6. **Commitment**: The goal of therapy is to make a client independent. The course of treatment requires commitment from both the therapist and the client. To strengthen independence, the therapist and client work together. The client may be given particular homework to practice at home. They will require to do the same. In case of not being able to complete the assignment, reasons will be discussed.
7. **Substance Use**: The client should not be intoxicated during the session. In such a case, the therapist can terminate the session.

EXCEPTIONS TO CONFIDENTIALITY

1. If you threaten to harm someone else, the therapist is required under the law to take steps to inform the intended victim and appropriate law enforcement agencies.
2. If you threaten to cause severe harm to yourself, the therapist is permitted to reveal information to others if they believe it is necessary to prevent the threatened harm.
3. If you reveal or therapist reasonable suspicion that any child, older person, or incompetent person is being abused or neglected, the law requires that we report this to the appropriate county agency.
4. If a court of law orders us to release information, the therapist must provide that specific information to the court.
5. In order to provide you the best treatment, there will be times when therapist may seek consultation from another licensed mental health professional. In these consultations, the therapist makes every effort to avoid revealing your identity. The consultant is also legally bound to keep the information confidential, although the exceptions to confidentiality apply to them as well. Similarly, when the therapist is away or unavailable, their practice is covered by a licensed therapist. They may inform the on-call therapist about your situation to facilitate their appropriate support should they need it in their absence.

Contact information

My current residential address and phone number:

_____

The contents of this form have been explained to me in a language that I understand.

After reading/listening to and understanding all of the above, I am giving my consent for:

Telephone/audio sessions ☐ Yes ☐ No

Video sessions ☐ Yes ☐ No

By returning this form, I indicate consent and understanding of the guidelines for these sessions.

Name with signature: Date:

NO SUICIDE AGREEMENT

As a part of my counseling, I_____will do the following things.

1. One of my major goals is to live a long life with more happiness than I now have.
2. I understand that wanting to kill myself and hurt myself gets in the way of this goal. I want to learn better things I can do when I feel bad. I want to find answers to my problems.
3. I understand that feeling better will take time not to hurt or kill myself and continue to see my counselor.
4. If at any time I want to hurt or kill myself I will tell _____or _____. If I cannot find _____ or _____ I will call _____ at _____ or _____ at _____.
5. My counselor will work with me to help me learn better ways to take care of my problems.
6. I will keep this agreement until I am in therapy at Home of Beautiful Souls.

Name:

Date:

Signatur: