Graceview Counseling Center
25510 Tomball Parkway Tomball, TX 77375
713-306-7061
www.Graceviewcc.com
graceviewcounseingcenter@gmail.com

TeleMental Health Therapy Services

TeleMental Health services should not be viewed as a complete substitute for therapy conducted in my office, unless there are extreme circumstances that prevent you from attending therapy in person. It is an alternative form of therapy or adjunct therapy, and it involves limitations. Primarily, there is a risk of misunderstanding one another when communication lacks visual or auditory cues. For example, if video quality is lacking for some reason, I might not see a tear in your eye. Or, if audio quality is lacking, I might not hear the crack in your voice that I could easily pick up if you were in my office. There may also be a disruption to the service (e.g., phone gets cut off or video drops). This can be frustrating and interrupt the normal flow of personal interaction. Please know that I have the utmost respect and positive regard for you and your wellbeing. I would never do or say anything intentionally to hurt you in any way, and I strongly encourage you to let me know if something I've done or said has upset you. I invite you to keep our communication open at all times to reduce any possible harm.

There are additional procedures that we need to have in place specific to TeleMental Health services. These are for your safety in case of an emergency and are as follows:

1. You understand that if you are having suicidal or homicidal thoughts, experiencing psychotic symptoms, or in a crisis that we cannot solve remotely, I may determine that you need a higher level of care and TeleMental Health services are not appropriate.

2. I require an Emergency Contact Person (ECP) who I may contact on your behalf in a life-threatening emergency only. Please write this person's name and contact information below. Either you or I will verify that your ECP is willing and able to go to your location in the event of an emergency. Additionally, if either you, your ECP, or I determine necessary, the ECP agrees take you to a hospital.

3. Your signature at the end of this document indicates that you understand I will only contact this individual in the extreme circumstances stated above.

Please list your ECP here: Name: ______________________________ Phone: ________________________

4. You agree to inform me of the address where you are at the beginning of every TeleMental Health session.

5. You agree to inform me of the nearest mental health hospital to your primary location that you prefer to go to in the event of a mental health emergency (usually located where you will typically be during a TeleMental Health session). Please list this hospital and contact number here: Hospital: ____ Phone: ________________________

Graceview Counseling Center
25510 Tomball Parkway Tomball, TX 77375
713-306-7061
www.Graceviewcc.com
graceviewcounseingcenter@gmail.com

In Case of Technology Failure: During a TeleMental Health session, we could encounter a technological failure. The most reliable backup plan is to contact one another via telephone. Please make sure you have a phone with you, and I have that phone number. If we get disconnected from a video conferencing or chat session, end and restart the session. If we are unable to reconnect within ten minutes, please call me. If we are on a phone session and we get disconnected, please call me back or contact me to schedule another session. If the issue is due to my phone service, and we are not able to reconnect, I will not charge you for that session.

Please check and initial below indicating that you have read and understand the contents of this form, you agree to these policies, and you are authorizing me to utilize the TeleMental Health method indicated below.

1. Phone session only _______ Initials: ________

2. Video/Online Session ______ Initials: ________

____ ________________

Client's Name: Print and sign Date

If Applicable: ____________________________________ _________________

Parent's or Legal Guardian's Name Date

My signature below indicates that I have discussed this form with you and have answered any questions you have regarding this information.

____

Therapist Signature/Date