



My Healio

for the days you feel too much



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CLIENT INFORMED CONSENT FORM

Informed consent for video/audio consultation with Clinical Psychologists¹ for psychotherapy
at _____ (insert Professional/Organization/Unit providing the service)

General Information provided to me

About Psychotherapy:

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

About Tele-psychotherapy:

Tele-psychotherapy refers to the provision of psychotherapy services using tele communication 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 own limitations as compared to in-person sessions and some details could potentially be missed out 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 that may be required at any given point of time. At the same time, I agree to not hold my psychotherapist responsible, should any adverse events, such as lack of improvement, deterioration or situations of potential risk of harm to self or others, occur during video/ audio consultation. I understand that in such situations I may be advised to obtain treatment at the nearest available mental health or emergency service.

¹ Herewith mentioned as 'Psychotherapist' in this Informed Consent Form

² Herewith referred to as 'Client' in this Informed Consent Form



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CLIENT INFORMED CONSENT FORM

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 audio or video 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 training of professionals. Apart from this, the details of the consultation 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 breach in security in technology. In such instances, both client and psychotherapist will not hold the other responsible for the breach.

Payment and Billing:

I understand that these consultations will be charged at the same rate as in-person sessions or at a lower rate that would be 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 that are available and suitable and that we will decide on what to use, considering my preference as well as the suitability of an option as assessed by my psychotherapist.

I understand that if there are any difficulties in communication (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 experience any difficulty in the process and in my best interest.



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CLIENT INFORMED CONSENT FORM

Consent:

I hereby provide my informed consent for video/audio consultations for tele-psychotherapy at _____ (Insert Name of Professional/Organization/Unit providing the Service).

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 for these sessions.

Name:

Date:



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PARENT/GUARDIAN INFORMED CONSENT FORM

Parent/ Guardian Informed consent for video/audio consultation with Clinical Psychologists³ for psychotherapy with child or adolescent at _____ (Insert Name of the Professional/Organization/Unit providing the service)

General Information provided to me

About Psychotherapy:

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

What I have understood about Tele-psychotherapy Services

About Tele-psychotherapy:

Tele-psychotherapy refers to the provision of psychotherapy services using tele communication 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.

Possible limitations to care:

I understand that video/audio consultation has its own limitations as compared to in-person sessions with my child and some details could potentially be missed out despite the psychotherapist's best efforts.

I understand that tele-psychotherapy services are by appointment only and that these consultations for my child are not suitable for help during a crisis or emergency. I understand that the psychotherapist contacted during a set appointment would evaluate my child's needs and guide me about the most suitable option for psychological intervention in that context (tele psychotherapy/ in-person psychotherapy/ crisis intervention/ emergency services).

³ Herewith mentioned as 'Psychotherapist' in this Informed Consent Form

⁴ Herewith referred to as 'Client' in this Informed Consent Form



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PARENT/GUARDIAN INFORMED CONSENT FORM

Responsibility for adverse events:

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

Confidentiality and Recording:

I understand that this audio/ video consultation is strictly confidential. I agree to provide a secure line/connection to my child for these consultations, in a relatively quiet and private space. I understand that my child's psychotherapist will not audio or video 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 and my child's assent, my child's psychotherapist could use it to have their work supervised or for training of professionals. Apart from this, the details of the consultation would be shared only with a court of law, if mandated.

Notes of the tele-psychotherapy consultation will be maintained by my child's 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 my child, me or my relatives / other contacts to any third person or through social media. However, despite safety measures taken, there are chances for breach in security in technology. In such instances, both client and psychotherapist will not hold the other responsible for the breach.

Payment and Billing:

I understand that these consultations will be charged at the same rate as in-person sessions or at a lower rate that would be 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 my child to receive tele-psychotherapy services.

I understand that my child's psychotherapist will discuss the tele and audio options that are available and suitable and that we will decide on what to use, considering my preference as well as the suitability of an option as assessed by the professional.



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PARENT/GUARDIAN INFORMED CONSENT FORM

I understand that if there are any difficulties in communication (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 child's wish to withdraw or continue these sessions will be considered.

I understand that my child's psychotherapist may also temporarily stop or discontinue these audio/video sessions/recommend any other method or line of treatment if either of us experience any difficulty in the process and in my child's best interest.

Consent:

I hereby provide my informed consent for video/audio consultations for tele-psychotherapy at _____ (Insert Name of Professional/Organization/Unit providing the Service).

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 for these sessions.

Name:

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MINOR ASSENT FORM (Applicable for children who are at least 7 years old)

When a person is feeling upset, or having some difficulties and wants to find ways that can help them feel better, think differently and do well, one way to help themselves is called 'Psychotherapy'. You will have a separate 'mind-doctor' or 'feelings- doctor' called a 'psychotherapist'.

Your psychotherapist will first try to understand your difficulties as well as possible. Then, in discussion with you and your parents, make an agreement about what difficulties to work on. The agreement will also decide on when, for how long and how often you will need to fix a time to discuss.

For different reasons, you and your psychotherapist could talk to each other using a phone or a computer. Your parent/ guardian will be asked for their permission for this. When and how long you would talk would be discussed in advance with you and your parents, each time. In some sessions, the therapist may talk to your parent/s or both you and your parent/s together in order to help you.

Nobody - neither you, your parents or your doctor/psychotherapist - will take photographs or record anything while you and your psychotherapist are talking. No information about these talks will be shared with anyone else. Sometimes, your psychotherapist may share information about your discussions with their supervisor/teacher.

Sometimes if you are too upset, talking over phone or computer would not be possible or helpful enough. In such situations, you may need to go to a hospital for urgent help and your parents will be guided about the closest suitable places where they can take you to.

Would you be comfortable talking to your psychotherapist over phone?

Yes ☐

No ☐

Would you be comfortable talking to your psychotherapist over video call?

Yes ☐

No ☐

Name:

Date:



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Therapy Session Recording Form (Name of the Institute/Hospital/Centre with address)

Clinic record no. _____

THERAPIST SESSION NOTES

Patient name: _____

Age: _____

Session number & date: _____

Gender: _____

Duration of session: _____

Psychiatric diagnosis: _____

Session Participants: _____

Therapy method:

- Individual

Objectives of the session:

1. _____
2. _____
3. _____
4. _____

Key issues/themes discussed: (Psychosocial stressors/Interpersonal problems/Intrapsychic conflicts/Crisis situations/Conduct difficulties/Behavioural difficulties/ Emotional difficulties/ Developmental difficulties/ Adjustment issues/ Addictive behaviours/Others)

Therapy techniques used:

Therapist observations and reflections:

Plan for next session:

Therapist

Name _____

Date _____

Qualification _____

RCI Registration Number _____

Signature _____

Supervised by (if applicable)

Name _____

Date _____

Qualification _____

RCI Registration Number _____

Signature _____