



**Johanna A. Limmer MC LPC LMHC NCC CCMHC**

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**Telemental Health Records, Sessions, and Communication Information**

This form is to share with you details around Telemental Health. I do offer Telemental Health sessions and communication between you and myself. I know that we may need to communicate outside of our sessions or outside of my regular business hours.

I want to let you know that I do keep electronic files. These files are password protected, and I am the only one with this password. I am also the only person with access to these files.

I also offer sessions over Telemental Health platforms, as I know sometimes this works better in your schedule or is your preference.

Also, I offer texting and phone calls up until 8pm every day of the week. If you need immediate assistance, it is important you contact 911 or the crisis team at 1(800)273-8255 or (775)784-8090, as my response may not be immediate. If you do contact me, you are agreeing to stay safe until I am able to return your message at my earliest convenience. Questions that are not crisis or need immediate responses, I ask that you contact me during my business hours of 8:00am-1:00pm, Monday-Friday. Sometimes, you may decide to go ahead and contact me. If I feel the response can wait until business hours, please note that I will respond when I return to my office during regular business hours.

All platforms I utilize are HIPPA compliant and I have Business Associate Agreements (BAA) on file. If you wish to review these, please let me know. By signing this form, you are consenting to Telemental Health records, sessions, and communication terms and conditions.

\_\_\_\_\_  
**Client Name (Please Print)**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Client Signature**

**If Applicable:**

\_\_\_\_\_  
**Parent's or Legal Guardian's Name (Please Print)**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Parent's or Legal Guardian's Signature**

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

\_\_\_\_\_  
**Therapist's Signature**

\_\_\_\_\_  
**Date**