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CONSENT TO TREATMENT

I acknowledge that I have received and understand the "Information for Clients/Professional Disclosure Statement" document, and I have had an opportunity to have all my questions answered fully.

I do hereby seek consent to take part in the treatment by the therapist named below. I understand that regularly reviewing our work together to meet your treatment goals is in my best interest. I agree to play an active role in this process.

I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

I understand that all information regarding diagnosis and/or treatment is confidential and will not be released to any other agency or individual without my knowledge and written consent, except when required by law.

I understand that CCC and my counselor are required to report knowledge of current child abuse. I also understand that CCC and my counselor may be released from confidentiality statutes if there is a serious intent to harm myself or others.

I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel prior to 24 hours in advance or do not show up, I could be charged for that appointment.

My signature below shows that I understand and agree with all of these statements.

Signature of client (or person acting for client)

Date

Printed name

Relationship to client *if not self*

I, Christine Leonard, have discussed the issues above with the client (and/or his or her parent, guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Signature of therapist

Date



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CLIENT INFORMED CONSENT AGREEMENT FOR TELEHEALTH SERVICES

This **Client Informed Consent Agreement For Telehealth Services** document contains important information focusing on doing psychotherapy using the phone and the Internet. Please read this document carefully and let me know if you have any questions that I may answer for you. When you sign this document, it will represent a binding agreement between us pursuant to the use of “Telehealth Services.”

1. Benefits and Risks of Telehealth Services: Telehealth refers to providing psychotherapy services remotely using telecommunications technologies, such as video conferencing and/or telephone. One of the benefits of Telehealth is that the client and clinician can engage in services without being in the same physical location. This can be helpful in ensuring continuity of care if the client or clinician moves to a different location, takes an extended vacation, or is otherwise unable to continue to meet in person. It is also more convenient and takes less time. Telehealth, however, requires technical competence on both our parts to be helpful. Although there are benefits of Telehealth, there are some differences between in-person psychotherapy and Telehealth, as well as some risks. For example:

A. Potential Risks to Confidentiality: Because Telehealth sessions take place outside of the therapist’s private office, there is potential for other people to overhear sessions if you are not in a private place during the session. On my end, I will take reasonable steps to ensure your privacy, and it is important for you to make sure you find a private place for our session where you will not be interrupted. It is also important for you to protect the privacy of our session on your cell phone, or other device. You should participate in therapy *only* while in a room or area where other people not meant to be included in the therapy session are *not* present and *cannot* overhear the conversation.

B. Issues Related to Technology: There are many ways that technology issues might impact Telehealth. For example, technology may stop working during a session, other people might be able to get access to our private conversation, or stored data could be accessed by unauthorized people or companies. *See Paragraph 1 for more detailed information on technological issues that could malfunction and how to address them.*

C. Crisis Management and Intervention: Usually, I will not engage in Telehealth with clients who are currently in a crisis situation requiring high levels of support and intervention. In any event, we will have an “Emergency Response Plan” to address potential crisis situations that may arise during the course of our Telehealth work.



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D. Efficacy: Most research shows that Telehealth is about as effective as in-person psychotherapy. However, some therapists believe that something is lost by not being in the same room.

2. Electronic Communications: I use a **HIPAA Compliant technology platform**, for audio video conferencing, and there is no cost to you for using this service. You will need to have a computer that has audio and video capabilities for us to use video conferencing. You will also need fairly reliable internet service. For communication between sessions, I only use email communication and text messaging with your permission and only for administrative purposes unless we have made another agreement. This means that email exchanges and text messages with my office should be limited to administrative matters. This includes things like setting and changing appointments, billing matters, and other related issues. You should be aware that I cannot guarantee the confidentiality of any information communicated by email or text. Therefore, I will not discuss any Clinical Information by email or text and prefer that you do not either. Also, I do not always regularly check my email or texts, so these methods **should not** be used if there is an **Emergency**.

Treatment is most effective when clinical discussions occur at your regularly scheduled sessions. But if an urgent issue arises, you should feel free to attempt to reach me by phone. I will try to return your call within 24 hours. If you are unable to reach me and feel that you cannot wait for me to return your call, contact your family physician or the nearest emergency room and ask for the clinician or psychiatrist “on call.” If I will be unavailable for an extended time, I will provide you with the name of a colleague to contact in my absence, if necessary.

3. Legal Proscription – Preventing Telehealth Counseling Services Outside South Carolina: It is important that I know your actual geographic location any time that we engage in Telehealth sessions. Where you are physically located may limit our ability to hold these sessions, as I am only provisionally licensed to practice in the state of South Carolina, and if you travel outside of the state, I would not be able to legally perform Telehealth Counseling Services with you during that time unless the state you travel to allows a licensed counselor from SC to practice counseling in that state. If necessary, I would assist you in finding a clinician in the local area you are located.

4. Confidentiality: I have both a legal and ethical responsibility to make my best efforts to protect all communications that are a part of our Telehealth sessions. However, the nature of electronic communications technologies is such that I **cannot guarantee** that our communications will be kept confidential or that other people may not gain access to our communications. I will use updated encryption methods, firewalls, and backup systems to help keep your information private, but there is a risk that our electronic communications may be compromised, unsecured, or accessed by others. You should also take reasonable steps on your end to ensure the security integrity of our communications (for example, only using secure



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networks for Telehealth sessions and having passwords to protect the device you use for Telehealth).

The extent of confidentiality and the exceptions to confidentiality that I outlined in my Professional Disclosure Statement and Confidentiality in Psychotherapy forms which were/are provided to you at the inception of therapy still apply in Telehealth. Please let me know if you have any questions about exceptions to confidentiality.

5. Procedural Issues: I am required to confirm your identity at the outset of our sessions. If it is our initial session, I would ask that you have a photo id available to show me on the video screen for this purpose. I may also ask you to pan the room to ensure no one who is not authorized or expected to be in the session is in attendance. I will also confirm your geographical location whenever we have a telehealth session. If you know you will be elsewhere in the state of South Carolina for a session, let me know ahead of time so that I can be knowledgeable of the local resources available in case there is an emergency.

6. Personal Emergencies and/or Technology Related Issues: Assessing and evaluating threats and other emergencies can be more difficult when conducting Telehealth than in traditional in-person therapy. To address some of these difficulties, we are creating an “Emergency Plan” before engaging in Telehealth services. You must identify an “Emergency Contact Person” who is near your location and who I **am authorized, by you,** to contact in the event of a Crisis or Emergency to assist in addressing an emergent situation. By executing this document, you are **authorizing/allowing me** to contact your “Emergency Contact Person”, as needed, during such a Crisis or Emergency.

My “**Emergency Contact Person**” is: _____

This person can be reached at: _____

If the Telehealth Counseling session is interrupted for any reason, such as the audio and/or video technological connection fails, *and you are having an emergency*, **do not call me back**; instead, **call 911**, or go to your **nearest Emergency Room**. Call me back after you have called or obtained requisite Emergency Services. Another option, in case of an emergency, is to call the **National Suicide Prevention Hotline** at 1-800-273-8255. We can also discuss other local resources that maybe available to you.

If the session is interrupted and you are *not* having an Emergency, disconnect from the session and I will attempt to re-contact you via the Telehealth platform on which we agreed to conduct therapy. If you do not receive a call back within two (2) minutes, then **immediately** call me at (803) 634-2926. If there is a technological failure and we are unable to resume the connection, you will only be charged the prorated amount of actual session time. TIP: If your computer is not



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plugged in-be sure your device is fully charged and/or be situated in close proximity to an appropriate electrical charging source. If you are tethering to get the internet, be sure your phone is also fully charged and that you are ready to plug in to an appropriate electrical charging source. AUDIO ISSUES: Sometimes the sound goes out; if this happens, I can call you on your phone and we can use the phone as our speakers while we still have the video connection. If only one side of the communication is having audio problems and your phone is on speaker, you may have to mute the microphone on the computer.

7. Records: The Telehealth sessions **shall not be recorded, in any way, by either party to this Agreement** UNLESS **agreed to, in writing, by Mutual Consent of the parties.** I will maintain a record of our session in the same way I maintain Clinical Records of in-person sessions - in accordance with all South Carolina State Legal, and Ethical Requirements pursuant to State Records Retention Policies.

This agreement is intended as a supplemental addendum to the Professional Disclosure Statement and Confidentiality in Psychotherapy documents that we agreed to, and executed, at the outset of our clinical work together. It **does not amend, nor negate,** any of the terms of the above-mentioned documents.

Your signature, below, indicates your voluntary willingness to execute this agreement and your personal acknowledgment that you will comply with all of its terms and conditions.

Client Legal Name

Date/Time

Therapist Legal Name

Date/Time