Telehealth Treatment Contract

I acknowledge that I am voluntarily authorizing and consent to receiving *Life's Light and Hope, PLLC* services via telehealth technologies. The electronic communications systems that are used will incorporate network and software security protocols to protect the confidentiality of client information and will include measures to safeguard data and to ensure its integrity against intentional or unintentional corruption.

Life's Light and Hope, PLLC will provide telehealth services using Doxy.me, which is a HIPAA compliant platform for telehealth services.

I understand that treatment will be rendered by appropriate professional personnel:
Sara E. Collins, LMSW.

- I may contact the therapist as the need arises at the telephone number or address provided to me.
- Successful termination of treatment is determined when the therapist and the client agree that the treatment goals have been substantially completed.
- There are fees for the services rendered and I have been informed of those charges and that I am responsible for those charges.
- If a check is returned NCF or uncollectable, any/all bank fees, plus a processing fee of $35.00, will be added to the amount due and owing.
- If I am entitled to insurance payments for this treatment, my therapist may assist me, but assumes no responsibility for collecting them
- If there is a balance on an account for which I am responsible, is not paid on monthly and/or the outstanding balance on my account is deemed too high by ***Life's Light and Hope, PLLC*** the therapist may cancel therapy sessions until the balance is brought up to date; however, the therapist will inform me of this practice no less than 24 hours before the scheduled appointment.
- **If I, the client, elect not to keep or cancel a therapy session less than 24 hours prior to the scheduled time, the therapist may charge me for this appointment. I recognize that my insurance will not cover this charge of $25.00. Any charges for late cancellations or missed appointments must be paid at the time of the next scheduled appointment.**
- If, in the event that my account is submitted for collections, all applicable fees will be assumed by me.
- The services offered by the therapist and the hours of operation have been clearly explained to me. In general, they are outpatient services for mental health issues. The therapist operates– Tuesday through Thursday from 12:00pm – 9:00pm. Availability on Friday from 12:00pm – 6:00pm primarily for telehealth services.
- As a client I understand that I have certain responsibilities which include the following:
  - The responsibility to actively participate in the development of a treatment plan

- To sign forms releasing information for client information when necessary since the therapist cannot provide information without written client consent.
- The responsibility to comply with this treatment contract and to carry out the provisions of my treatment plan
- I understand that I may be discharged by the therapist for the following:
  - The client has completed the planned course of treatment with an acceptable degree of success
  - The client chooses to termination services
  - The therapist feels that termination is the most reasonable option, given the client's particular response to treatment
  - Other circumstances make it necessary to discontinue treatment due to hardships or impracticality, i.e. job transfer or family relocation
  - The therapist cannot provide services in a professional and ethical manner in compliance with the standards of all regulatory bodies
  - The client fails to maintain contact with the therapist for a period of more than 30 days
  - The client fails to comply with the provisions in this contract
- Repeated failure to attend scheduled appointments will result in case closure, at the discretion of the therapist

- Clients are asked to wear appropriate clothing during telehealth sessions. Dress as if you were to attend an in-person session.
- By signing this agreement, I hearby agree to all provisions of the Telehealth Treatment Contract and agree that I have requested the services described to me herein. I further attest that I have read my rights under the federal and state statutes for mental health services. If I have requested a copy of this information, a copy has been provided to me. I acknowledge that I have been made aware of my rights as they apply to HIPAA.
- I, the undersigned, understand that I may revoke this consent at any time except to the extent that action has been take in reliance upon it, and that in any event, this consent shall remain active until discharge from treatment at ***Life's Light and Hope, PLLC.***

POSSIBLE RISKS OF TELEHEALTH SERVICES

- Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment or technologies.
- In rare events, the provider may determine that the transmitted information is of inadequate quality, thus necessitating a rescheduled telehealth session, a telephone session, or a referral to a local psychologist, social worker, or counselor as applicable.
- In very rare events, security protocols could fail, causing a breach of privacy or of personal health information.

In the event of an inability to communicate as a result of technological or equipment failure, please contact ***Life's Light and Hope, PLLC*** at 734.582.4294 (phone) or 734-265-0554 (text).

SERVICE LIMITATIONS

- ***Life's Light and Hope, PLLC*** does not address urgent cases. If you believe that you are experiencing an emergent concern, you should dial 911 and/or go to the nearest urgent care center or emergency room. After receiving urgent healthcare treatment, you should follow up with your primary care doctor.
- ***Life's Light and Hope, PLLC*** is and addition to, and not a replacement for, your primary care doctor. Responsibility for your overall medical care should remain with your local primary care doctor, if you have one, and it is strong in encouraged that you locate one if you do not.
- If ***Life's Light and Hope, PLLC*** believes that you would be better served in another form of psychotherapeutic services (i.e. in-person services), this will be discussed in session.

INFORMED CONSENT

- I understand that *Life's Light and Hope, PLLC* offers telehealth-based psychotherapy services but that these services do not replace the relationship between me and my primary doctor. I also understand that it is up to *Life's Light and Hope, PLLC* to determine whether or not my specific clinical needs are appropriate for a telehealth encounter.
- I understand that federal and state law requires health care providers to protect the privacy and the security of health information. I understand that *Life's Light and Hope, PLLC* will take steps to make sure that my health information is not seen by anyone who should not see it.
- I understand that there is a risk of technical failures during the telehealth encounter beyond the control of *Life's Light and Hope, PLLC*. I agree to hold harmless *Life's Light and Hope, PLLC* for delays in evaluation or for information lost due to such technical failures.

Please indicate your preference(s) of contact (Check all that apply)

( ) Cell Telephone ……

( ) Work Telephone ……

( ) OK to leave message with detailed information

( ) OK to text this number

( ) Leave message with call back number only

( ) OK to mail to my home address

( ) OK to mail to my work/office address

( ) OK to fax to this number _____

( ) Other: Please describe: _____

_____

_____

_____

Client or Legal Guardian Date

_____

Client or Legal Guardian Date

_____

Clinician Date