ALLIANCE COUNSELING, LLC *David Clegg, EdD, MEd, LPC (AZ), LMHC (WA)*	
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Tele-Practice Informed Consent

I _____ [name of client(s)] understand(s) there may be times when Alliance Counseling, LLC ("Alliance Counseling") and/or its counselors wishes me to engage in tele-practice treatment services.

I understand that "tele-practice" means providing behavioral health services through interactive audio, video or electronic communication that occurs between a behavioral health professional and the client, including any electronic communication for evaluation, diagnosis, and treatment, including distance counseling, in a secure platform.

Alliance Counseling has explained to me how and why tele-practice services may be used. Alliance Counseling has explained to me that Alliance Counseling is not responsible for a client's inability to participate in a session virtually. I understand that in the event I am unable to participate in a session virtually, the cancellation procedures outlined in the Informed Consent Agreement that I signed at the beginning of treatment remain in effect and I remain responsible to pay for the session if I do not provide 24 hours' notice to cancel a session.

I understand there are potential risks to this technology including technological and other interruptions, unauthorized electronic access, and technical difficulties. Unlike in an office setting, Alliance Counseling cannot guarantee the confidentiality of the location that I choose for conducting teletherapy. In addition, the use of technology in any setting, including therapy, carries with it inherent confidentiality risks. I understand that Alliance Counseling or I can discontinue the tele-practice visit if it is felt that the connection is not adequate for the situation. I understand that I may benefit from tele-practice, but that results cannot be guaranteed or assured.

In cases where electronic communication does not involve video (such as phone therapy), Alliance Counseling will identify me by using voice recognition and confirmation of my date of birth to ensure confidentiality. In addition, at the beginning of each session regardless of method of telehealth delivery, my counselor will ask to confirm my physical location and that my local emergency contacts have not changed.

Emergency procedures will be the same as previously stated in the Informed Consent Agreement that I signed at the beginning of treatment. I understand that if I feel unable to keep myself safe or in the event of an emergency, I should call 911 or the local crisis response center at (602)-2229444 or go to my nearest emergency room and ask to speak to the psychiatrist or psychologist on call.

The laws that protect the confidentiality of my medical and mental health information also apply to tele-practice. As such, I understand that the information disclosed by me during the course of my counseling is generally confidential, even in tele-practice. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards self and/or an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. I understand that the payment structure for services does not change when tele-practice options are utilized.

I have had a direct conversation with my Alliance Counseling counselor about the risks and benefits related to the utilization of tele-practice and had the opportunity to ask questions regarding this option. I acknowledge my questions have been answered.

I have the option of revoking this consent at any time tele-practice services are no longer needed or beneficial.

I understand that I have a right to access my medical and mental health information and copies of medical records in accordance with Arizona law. I have read and understand the information provided above. I have discussed it with my counselor, and all of my questions have been answered to my satisfaction.

Printed Name of Client :_____ Date of Birth:_____

Signature of Client:_____ Date:_____

Relationship (If other than Client, Parent/Guardian/Conservator):

_____

Signature of Alliance Counseling Counselor: _____ Date:_____

Local Emergency Contact Name (person in same or nearby location where you will partke in teletherapy) and Phone Number:

NAME/RELATIONSHIP: _____PHONE: _____