Resilient Journeys, PLLC

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Telehealth Virtual Office: https://doxy.me/resilientjourneys

Telehealth Informed Consent Form

I _____, consent to engaging in telehealth with Resilient Journeys, PLLC as a part of the therapy process and my treatment goals. I understand that telehealth psychotherapy or EAP sessions may include mental health evaluation, assessment, consultation, treatment planning, and therapy. Telehealth will occur primarily through interactive audio, video, telephone and/or other audio/video communications.

I understand I have the following rights with respect to telehealth:

1) I have the right to withhold or remove consent at any time without affecting my right to future care or treatment, nor endangering the loss or withdrawal of any program benefits to which I would otherwise be eligible.

2) The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information released by me during the course of my sessions is generally confidential. There are both mandatory and permissive exceptions to confidentiality including but not limited to reporting child and vulnerable adult abuse, expressed imminent harm to oneself or others, or as a part of legal proceedings where information is requested by a court of law. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent,

3) I understand that there are risks and consequences from telehealth including but not limited to, the possibility, despite reasonable efforts on the part of Resilient Journeys, PLLC that: the transmission of my personal information could be disrupted or distorted by technical failures and/or the transmission of my personal information could be interrupted by unauthorized persons.

   In addition, I understand that telehealth-based services and care may not be as complete and in-person services. I understand that if my therapist believes I would be bettered served by other interventions I will be referred to a mental health/substance use professional who can provide those services in my area. I also understand that there are potential risks and benefits associated with any form of mental health/substance use treatment, and that despite my efforts and efforts of my therapist, my condition may not improve, or may have the potential to get worse.

4) I understand that I may benefit from telehealth services, but that results cannot be guaranteed or assured. I understand that the use of telehealth technology may have issues with Wi-Fi and internet connectivity. All attempts to keep information confidential while using these systems will be made but a guarantee of 100% confidentiality cannot be made with inherent

issues with these communication systems. Signing this form shows an awareness of these issues and a decision by this client to use these systems for telehealth services. I will not hold Resilient Journeys, PLLC or its staff liable for gathering or use of client information by these service providers.

5) I understand that if I elect to communicate with my therapist by email that email is not completely confidential and therefore, I will limit email contact to communication related to the coordination of therapy appointments, such as appointment scheduling.

6) I have discussed these points with my therapist, and all of my questions regarding the above matters have been answered to my approval.

7) By signing this document, I agree that certain situations including emergencies and crises are inappropriate for audio/video/computer-based psychotherapy services. If I am in crisis or in an emergency, I should immediately contact emergency services (in the United States of America, please call 911) or go to the nearest hospital or crisis facility. By signing this document, I understand that emergency situation may include thoughts about hurting or harming myself or others, having uncontrolled psychotic symptoms, if I am in a life threating or emergency situation, if I am using drugs or alcohol at a high risk level, and you may not be safe from therapist's professional judgement.

Signature of client/parent/guardian Date

Printed name of client/parent/guardian Relationship (If applicable)