Wellspring Clinical Associates

5950 State Route 53 Unit W

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Teletherapy Informed Consent Form

Providers: Margaret Byrnes, PhD; Patti Boheme, LCPC; Sarah Czopek, LCPC; Tom DiMatteo, PharmD, MD; Bonnie Knox, M.Ed., LCPC, CADC; Soo Lee, MD; Phil Martinez, MA, LCPC; Kary Pekarek, LCSW; Maureen Taylor, LCPC

I _____ hereby consent to engage in teletherapy/coaching with Wellspring Clinical Staff as noted above. I understand that "teletherapy" includes consultation, treatment, transfer of medical data, emails, telephone conversations and education using interactive audio, video or data communications, as well as medical evaluation and management services when applicable. I understand that teletherapy/ coaching also involves the communication of my medical/mental information, both orally and visually.

I understand that I have the following rights with respect to teletherapy:

1. I have the right to withhold or withdraw consent at any time by written request without affecting my right to future care or treatment.
2. The laws that protect the confidentiality of my medical information also apply to teletherapy. As such, I understand that the information disclosed by me during the course of my therapy or consultation is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, which are discussed in detail with the general policies of Wellspring Clinical Associates, which I have received and is available at www.wca-il.com.
3. I understand that there are risks and consequences of teletherapy, including, but not limited to, the possibility despite reasonable efforts on the part of Wellspring Clinical Associates providers that:
    a. The transmission of my information could be disrupted or distorted by technical failures
    b. The transmission of my information could be intercepted by unauthorized persons, and
    c. The electronic storage of my medical information could be accessed by unauthorized persons.
4. In addition, I understand that teletherapy based services and care may not be as complete as face-to-face services. I understand that in the usual course of interaction, Wellspring Clinical

Associates and its staff require face-to-face contact when safe and available. I agree to use teletherapy only as absolutely necessary.

5. Finally, I understand that there are potential risks and benefits of any form of psychotherapy or psychiatric care, and that despite my efforts and the efforts of my provider, my condition may not improve, and in some cases may get worse.
6. I understand that I may benefit from teletherapy, but that results cannot be guaranteed or assured.
7. I accept that teletherapy does not provide emergency services, and that Wellspring Clinical Associates is an outpatient clinic that is not equipped for emergency mental health care. I understand that should I find myself or child in an emergency situation that I should call 911 or if safe to transport proceed to the nearest emergency room for help. If I am (or my child is) having suicidal thoughts, or there is any imminent concern for harm to self or others, I can call the National Suicide Prevention Lifeline at 1-800-273-TALK (800-273-8255) for free 24-hour hotline support.
8. I understand that I am responsible for:
    a. Providing the necessary computer. Telecommunications equipment and internet access for my teletherapy sessions.
    b. The information security on my computer or device
    c. Arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session.
9. I understand that confidentiality of emails cannot be guaranteed and that clinical information should not be transmitted in this manner unless expressly discussed with my provider. I understand that I should never use email for any urgent matter.
10. I understand that I have a right to access my medical information and copies of medical records in accordance with HIPAA privacy rules and applicable state law.

I have read, understand and agree to the information provided herein.

Name of client (printed) _____

Email address (for teletherapy link) _____

_____ _____

Client signature (12 and older) **Date**

_____ _____

Parent/guardian signature **Date**