Resilient Hearts Therapy

TELEHEALTH POLICY AND CONSENT

Definition of Services:

This document indicates consent for remote counseling/therapy sessions, online clinical consultations, or other related mental health services, otherwise known as telehealth or teletherapy, to be conducted via a HIPAA compliant media platform. These services may include the use of electronics such as telephone/smartphone, PC or laptop computer, or other means of interactive technology to access audio, video, email, and/or alternative media to engage in teletherapy.

Teletherapy serves the same purpose and intention as psychotherapy sessions that are conducted in office, and in many cases, may benefit a client as well as sessions conducted in person. Telehealth services may not be appropriate for all clients and situations. If, at any point, the therapist does not recommend teletherapy, every effort will be made to offer an office appointment or referral.

Security

Clients are entitled to confidentiality and best efforts will be made by the therapist to maintain this right during online therapy. Clients are responsible for providing the necessary computer or telecommunications equipment and internet access for their teletherapy sessions, and arranging a location with enough lighting and privacy that is free from distractions or intrusions during sessions. Transmitting personal information via the Internet (including email) or phone should be done with discretion, as security cannot be guaranteed. When using electronic communication that does not involve video, client identity and location will be verified by the therapist using a method agreed upon by client and therapist during the initial session (i.e. date of birth, physical address, security question).

Limitations

Online therapy is intended to provide quality information and assistance with psychological issues and present problems. It may, however, not be the best option for in--depth psychotherapy and more intensive techniques, such as EMDR for trauma.

Technical Difficulties/Service Disruption

It should be understood that, when communicating by Internet or other electronic means, disruption of service or other technical difficulties are likely to occur from time to time. Sessions will be completed in the time designated, if the problem can be corrected. If it cannot be corrected within the first thirty (30) minutes, the session will be rescheduled. If a disruption occurs at the time of crisis, the patient is responsible for contacting the counselor immediately by phone at *(480) 382-6077* or dialing 911.

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TELEHEALTH POLICY AND CONSENT ACKNOWLEDGEMENT

When should I seek traditional therapy rather than online teletherapy?

1. If you are having thoughts of harming yourself or someone else, or psychotic symptoms (e.g., hallucinations). **In the case of harm to self or others, please call 911 or 1--800--SUICIDE** (National Suicide Hotline).
2. If you are in an abusive or violent relationship.
3. If you are experiencing severe depression.
4. If you struggle with significant substance abuse dependence.

Client's Rights, Risks, and Responsibilities

Please initial and sign:

_____I understand that I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.

_____I understand that the laws that protect the confidentiality of my health information also apply to teletherapy, and that the information disclosed by me during the course of my therapy is confidential, with the same ethical and legal exceptions regarding rules and laws for mandated reporting of danger or harm to self or others.

_____I understand that there are risks and consequences of participating in teletherapy, including, but not limited to, the possibility that despite best efforts to ensure high encryption and secure technology, our session could be disrupted or distorted by technical failures.

_____I understand that while telehealth or teletherapy treatment has been found to be effective in treating a wide range of disorders, there is no guarantee that all treatment of all clients will be effective.

I have read and understand the information provided above regarding telehealth. I hereby give my informed consent for the use of telehealth or teletherapy in my care or the care of my minor child.

_____	_____	_____
Client/Guardian Name Printed	Client/Guardian Signature	Date
_____	_____	_____
Therapist/Witness Name Printed	Therapist/Witness Signature	Date

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CONSENT TO USE THE TELEHEALTH BY SIMPLEPRACTICE SERVICE

Telehealth by SimplePractice is the technology service we will use to conduct telehealth videoconferencing appointments. It is simple to use and there are no passwords required to log in. By signing this document, I acknowledge:

- Telehealth by SimplePractice is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
- Though my provider and I may be in direct, virtual contact through the Telehealth Service, neither SimplePractice nor the Telehealth Service provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
- The Telehealth by SimplePractice Service facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.
- I do not assume that my provider has access to any or all of the technical information in the Telehealth by SimplePractice Service – or that such information is current, accurate or up-to-date. I will not rely on my health care provider to have any of this information in the Telehealth by SimplePractice Service.
- To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

By signing this form, I certify:

1. That I have read or had this form read and/or had this form explained to me.
2. That I fully understand its contents including the risks and benefits of the procedure(s).
3. That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

_____	_____	_____
Client/Guardian Name Printed	Client/Guardian Signature	Date
_____	_____	_____
Therapist/Witness Name Printed	Therapist/Witness Signature	Date