Hope Healing Joy Counseling Center, LLC

Informed Consent for Tele-health Service: Tele-behavioral health is the delivery of behavioral health services using electronic communications that enable Hope Healing Joy clinicians to connect with individuals using live interactive video and audio communications. The interactive technologies use software protocols to protect the confidentiality of client information transmitted via any electronic channel and has safeguards to protect data and aid in protecting intentional or unintentional corruption. I understand that I have rights with respect to tele-health:

1. The laws that protect confidentiality of my personal information that I have already signed in clinician's Declaration of Practice also apply to tele-health. A copy of this can be found under your clinician's name on our website, Hopehealingjoy.com.
2. I understand that I have the right to withhold or withdraw my consent to use tele-health in the course of my care at any time, without affecting my right to treatment.
3. I understand that there are risks and consequences of tele-health, including but not limited to, the possibility despite reasonable efforts not the part of the counselor, that the transmission of my personal information could be disrupted or distorted due to technical failures, the transmission of my personal information could be unintentionally lost or accessed by unauthorized persons. HHJ uses secure, encrypted HIPPA compliant audio/video transmission software to deliver tele-health via doxy.me. You can visit Doxy.me for more information. However if technology fails, utilization of Psychology Today Therapist Finder HIPPA compliant video platform may be used.
4. If services are disrupted, clinician will call the cell phone number I have provided. By signing this I am granting access to being called by clinician. In addition, if there is a reason to believe an emergency situation has arose clinician will call my emergency contact and/or the emergency department nearest you. If I wish to change my emergency contact or live outside the Lafayette area, please provide the number to the area that serves me, i.e. police department or sheriff department's phone number.
5. Clinicians follow the State of Louisiana Counseling Board Regulations for tele-health and have received education LA LPC Board requires hours for tele-health.
6. 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 call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in my immediate area.
7. It is my responsibility to maintain privacy on the client end of communication. I will take precautions to ensure my communications are directed only to my clinician.

Payment: Hope Healing Joy will bill insurance for tele-behavioral health and if covered, client will be responsible for standard copay and/or deductibles. However, if your insurance does not cover tele-behavioral health you may wish to pay out of pocket. We can provide you with a statement of service to submit to your insurance.

Client Consent: I have read and understand the information provided above regarding tele-behavioral health. I have discussed it with my counselor, and all my questions have been answered to my satisfaction. I have read this document carefully and understand the risks and benefits related to the use of tele-behavioral health services and have had my questions regarding the procedure explained.

I hereby give my informed consent to participate in the use of tele-behavioral health services for treatment under the terms described herein. By my signature below, I hereby state that I have read, understood and agree to terms of this document.

Print name_____ Client Signature_____ Date_____

Therapist name_____ Therapist Signature_____Date_____

This information will only be used in the event of an emergency. In the event that your safety is threatened, or you pose a threat to others, we are required to contact the appropriate authorities. Please complete the following for emergency only.

First Name:
Middle Name:

Hope Healing Joy Counseling Center, LLC

Last Name:
Date of Birth:
Phone Number:

Location(s) you will receive telehealth services.
Physical Address:
City:
Parish:
Zip Code:
Nearest Police Department:
Police Phone Number:

(Alt) Physical Address:
City:
Parish:
Zip Code:
Nearest Police Department:
Police Phone Number:

Vehicle Information
Make:
Model:
Year:
Color:
License Plate:

Emergency Contact Person(s)
Please name NEARBY person(s) that you allow permission to be contacted in case of an emergency.

First Name:
Last Name:
Relationship:
Phone Number:

(Alt) First Name:
Last Name:
Relationship:
Phone Number:

I attest that the above information is correct and give permission to contact the above as my Emergency Contact Person(s) in the event of an emergency.

Signature: _____