Telehealth Informed Consent Form

I, _____consent to receive psychological treatment via telehealth with Coffee with Casey Counseling, LLC to facilitate both my access to professional services and my treatment goals. I understand that telehealth services may include evaluation, assessment, consultation, treatment planning, as well as psychological coaching and counseling. Telehealth will occur primarily through HIPAA compliant interactive audio, video, telephone and/or other audio/visual 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. 2. The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand the information released by me during the course of my sessions is confidential. 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 Coffee with Casey Counseling, LLC 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.4. In addition, I understand that telehealth-based psychological services may not be as comprehensive as in-person services. I understand that if my therapist believes I would be best served by other interventions (i.e. in-person treatment), I will be referred to a more appropriate mental health provider. If I am in crisis or I am experiencing a medical or psychiatric emergency, I should immediately call 911 or go to the nearest hospital or crisis facility. 5. By signing this document, I understand that emergency situations may include thoughts about hurting or harming myself or others, having uncontrolled psychotic or manic symptoms, experiencing a life threatening or emergency situation, abusing drugs or alcohol or experiencing other concerns which may present a risk to your safety. I have read and understand the above information and agree to participate in telehealth services with Coffee with Casey Counseling, LLC.

Client's Signature: _____ Date:_____

Client's Printed Name: _____

Client's Address (physical location during telehealth sessions): _____
_____

Emergency Contact Name/Telephone Number: _____