

**Counseling Connection Training Institute, PLC  
525 Hercules Drive Suite 1A, Colchester, VT 05446  
(802) 264-5333 ext. 108 or (802) 391-0648 (cell)**

## **Client Information and Informed Consent for Telehealth Treatment**

**This consent and phone contact information are for the clients of:**

**Vera Mikhailova, MS., Rostered  
under the supervision of Leora Black, PhD, LCMHC, LMFT**

Telehealth services or telemental health services involve the use of electronic communications to enable therapists to provide services to individuals who are located at a different site than the provider and may otherwise not have adequate access to care. **Vera Mikhailova, MS., Rostered** uses videoconferencing telehealth for therapeutic appointments in temporary special circumstances (e.g. health quarantine or office building inaccessibility) determined between client and therapist.

### **Points for Client Understanding:**

- I understand that I should be located in a private place during my session and that my technology should be as up to date as possible.
- I understand that telehealth services are completely voluntary and that I can choose not to participate or not to answer questions at any time.
- I understand that none of the telehealth sessions will be recorded or photographed without my written permission.
- I understand that the state and federal laws that protect privacy and the confidentiality of client information also apply to telehealth, as do the limitations to that confidentiality discussed in the disclosure and consent to treat document. I also understand that no information obtained in the use of telehealth that identifies me will be disclosed to other entities without my consent.
- I understand that telehealth is performed over a secure communication system that is almost impossible for anyone else to access, but because there is still a possibility of a breach, I accept the very rare risk that this could affect confidentiality.
- I understand that there is a risk that transmitted information may be lost due to technical failures.
- My therapist has explained to me how video conferencing technology will be used. I understand that any telehealth sessions will not be the exact same as an in-person session due to the fact that I will not be in the same room as my therapist.
- I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that I or my therapist may discontinue the telehealth sessions at any time if it is felt that the videoconferencing connections are not adequate for the situation.
- I understand that if there is an emergency during a telehealth session, my therapist will call emergency services and/or my emergency contact(s).
- I understand that if the video conferencing connection drops while I am in a session, I will have an additional phone line available to contact my therapist, or I will make additional plans with my therapist ahead of time for re-contact.
- I understand that I am required to provide a safety plan to my therapist in case of an emergency (see below).
- I understand that telehealth-based services may not be appropriate for everyone seeking therapy. I also understand that I or my therapist may determine that telehealth is not an appropriate intervention at any time, and if appropriate, I will be referred to a practitioner who can provide necessary services in my area.

- I understand that this form is signed in addition to the client disclosure and informed consent document and that all policies and procedures within that document apply to telehealth services.
- I understand I will be requested to access websites or install applications specific to treatment on my phone, tablet or computer device.
- I understand I have the right to withhold or withdraw this consent at any time.
- I understand that I will be responsible for any copayments or co-insurances that apply to my telehealth visit.

**Consent:**

I have read, understand, and consent to engaging in telehealth as part of my treatment with:

**Vera Mikhailova, MS., Rostered**

**Signatures:**

\_\_\_\_\_  
(Client - print)

\_\_\_\_\_  
(Client or Parent/Guardian Signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Practitioner's Signature)

\_\_\_\_\_  
(Date)

By signing this consent, **Vera Mikhailova, MS., Rostered** attests that the condition being treated is appropriate for telehealth encounters. **Vera Mikhailova, MS., Rostered** also attests that the telehealth platform used has been identified to be secure and HIPAA-compliant, and that all exchanges will be treated with the same security and privacy measures used for in-person appointments (within the limits of the technology).

## Telehealth Safety Plan Addendum

Client Name (first and last): \_\_\_\_\_

Physical Address of Client during telehealth sessions:

Street: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

(It is required that the client announce their location at each session when using videoconferencing, and it may be required that the client be at that same location for each session for the purposes of insurance payments.)

Client's Phone Number: \_\_\_\_\_ Alternative Phone Number: \_\_\_\_\_

Emergency Contact (1): \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_ City/State: \_\_\_\_\_

Emergency Contact (2): \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_ City/State: \_\_\_\_\_

Local Hospital (local to telehealth location of client): \_\_\_\_\_

Phone Number: \_\_\_\_\_

- I have provided at least one emergency contact number and the number to the local hospital or other facility as deemed appropriate.
- If there is an emergency during a session, my therapist has permission to contact my emergency contact(s) and/or the local hospital.
- I have provided a working telephone number to reach me if the video conferencing connection fails during a session.
- My therapist has provided me with a contact number. If connections fail and my counselor does not call me back within 5 minutes, then I will call my therapist.

### Signatures:

\_\_\_\_\_

Client

\_\_\_\_\_

Date

\_\_\_\_\_

\_\_\_\_\_

Therapist – **Vera Mikhailova, MS., Rostered**

Date