Let's Check In Counseling and Consulting, PLLC

Kristal Jackson, M.S., LPC

INFORMED CONSENT FOR TELEHEALTH

Telehealth allows my therapist to diagnose, consult, treat and educate using interactive audio, video and/or data communication regarding my treatment. *I hereby consent to participating in telehealth psychotherapy via HIPPA compliant platforms that Kristal Jackson, M.S., LPC, has chosen, such as* ***Doxy*** *or* ***GoogleDuo****.*

Client Name:_____ Date: _____

I understand I have the following rights under this agreement: *(Please initial after each paragraph after reading where indicated)*

I have a right to confidentiality with telehealth under the same laws and guidelines that protect the confidentiality of my protected health information (PHI) during in-person psychotherapy. Any information disclosed by me during the course of my therapy, therefore, is generally confidential. As with in-person therapy, the exceptions to confidentiality remain the same. These include: mandatory reporting of child, elder, and/or dependent adult abuse, along with any threats of violence I may make towards a reasonably identifiable person. I also understand that if I am exhibiting suicidal ideation and pose a risk to myself or others, my therapist is required to break confidentiality to prevent the potential harm to myself or others. _____

I understand the dissemination of any personally identifiable images or information from the telehealth interaction to any other entities shall not occur without my written consent. _____

I understand that, while psychotherapeutic treatment of all kinds has been found to be effective in treating a wide range of mental disorders and personal and relational issues, there is no guarantee that all treatment of all clients will be effective. Thus, I understand that while I may benefit from telehealth, results cannot be guaranteed or assured._____

I understand there are risks unique and specific to telehealth, including but not limited to, the possibility that our therapy sessions could be disrupted or distorted by technical failures. I also understand my therapist has made every effort to use a reliable platform to minimize these potential disruptions. _____

My therapist has instructed me to find a safe and secure location within my chosen environment for therapy/counseling sessions. I am aware that my sessions could be interrupted or overheard by unauthorized persons within my personal environment and that my therapist is not responsible for these personal disruptions. _____

In addition, I understand telehealth treatment is different from in-person therapy. If my therapist believes I would benefit from in-person treatment and is able to provide in-person sessions, these arrangements will be discussed and decided upon within the clinical relationship.

_____

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Not unlike in-person counseling sessions, I understand that it is my responsibility to verify my telehealth psychotherapy sessions with my insurance provider. Should my insurance company deny telehealth psychotherapy sessions, I agree to pay my provider no more than the contracted insurance rate for that service. _____

I have read and understand the information provided above. I have the right to discuss any of this information with my therapist and to have any questions I may have regarding my treatment answered to my satisfaction. _____

I understand that I can withdraw my consent to telehealth communications by providing written and/or verbal notification and termination of telehealth consent to Kristal Jackson, M.S., LPC-Intern _____

My signature below indicates that I have read this Agreement and agree to its terms.

_____ _____

Client name (printed) Date

_____

Client or authorized representative signature

Kristal Jackson, M.S., LPC
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