

Informed Consent for Telehealth and Online Counseling Services

About Consent: Read this consent thoroughly for understanding and ensure all of your questions are answered before signing to give consent.

Definition: Online therapy or telehealth involves the use of technology to conduct therapy or other psychological or mental health services.

Benefits: The benefits of telehealth include the convenience of location, time, wait times, and accessibility which allows for better continuity of care. In addition, telehealth allows for greater accessibility to services for clients with limited mobility or with lack of transportation.

Technological limitations: As with all technology, there are some limitations. Technology may occasionally fail before or during a session. The problems may be related to internet connectivity, difficulties with hardware, software, equipment, and/or services supplied by a third party. Any problems with internet availability or connectivity are outside the control of the therapist and the therapist makes no guarantee that such services will be available or work as expected. If something occurs to prevent or disrupt any scheduled appointment due to technical complications and the session cannot be completed via online video, the therapist will call you back to complete the session or to reschedule.

Emergency instructions: Before each video session, the therapist will need to know your (and your child's) location if you are not in your home, such as if you are currently not in your home but rather on vacation or elsewhere. If, for any reason, we are unable to connect and you are in an immediate crisis or a potentially life-threatening situation, get immediate assistance by calling 911.

Parent/Guardian Responsibility: I AGREE TO TAKE FULL RESPONSIBILITY FOR THE SECURITY OF ANY COMMUNICATIONS OR TREATMENT ON MY OWN (OR MY CHILD'S) COMPUTER OR DEVICE AND IN MY OWN PHYSICAL LOCATION. I understand that I am responsible for using this technology in a quiet, secure, and private location to ensure confidentiality.

Confidentiality: I understand that there will be NO recording of any of the telehealth sessions (i.e., no screen shots taken, etc) and that all information disclosed within sessions and the written records pertaining to those sessions are strictly confidential and may not be revealed to anyone without my written permission, except where disclosure is required by law. I understand that any unauthorized recordings of sessions are grounds for termination of the client-therapist relationship.

Consent to Treatment: I voluntarily consent to allow my child to receive online therapy (or other services as prescribed). I will support and participate in the planning, treatment, and/or services for my child as indicated by the therapist. I further understand that I may withdraw my consent for treatment or services that I receive through Ern and Associates, LLC.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_