Restoring Balance Counseling, LLC

Teletherapy Consent

Teletherapy is a form of psychological service provided via internet technology, which can include consultation, treatment, transfer of medical data, emails, telephone conversations and/or education using interactive audio, video, or data communications. I also understand that teletherapy involves the communication of my medical/mental health information, both orally and/or visually.

Teletherapy has the same purpose or intention as psychotherapy or psychological treatment sessions that are conducted in person. However, due to the nature of the technology used, I understand that teletherapy may be experienced somewhat differently than face-to-face treatment sessions. Teletherapy based services may not be as complete as face-to-face services.

1. I understand that my therapist wishes me to engage in a teletherapy consultation.
2. I, the client, have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
3. The laws that protect the confidentiality of my medical information apply to teletherapy and my rights are detailed in the form CLIENT RIGHTS and INFORMED CONSENT (signed), and HIPAA forms given to me and available on the RBC website and through the Client Portal.
4. I understand that there is a risk of being overheard by anyone near me if I am not in a private room while participating in teletherapy. I am responsible for (1) providing the necessary computer, phone, telecommunication equipment and internet access for my teletherapy sessions, and (2) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session. It is the responsibility of the therapist to do the same on their end.
5. I understand there are risks and consequences of participating in teletherapy, including, but not limited to, the possibility, despite best efforts to ensure high encryption and secure technology on the part of my therapist, that: the transmission of my information could be interrupted by unauthorized persons. HIPAA compliant technology is being used by my therapist to help ensure an appropriate level of encryption and technical confidentiality for our sessions.
6. There are risks that services could be disrupted or distorted by unforeseen technical problems.
7. I understand that I may benefit from teletherapy, but results cannot be guaranteed or assured. I understand that there are risks and benefits associated with any form of psychotherapy, and despite my efforts and the efforts of my therapist, my condition may not improve, and in some cases may get worse.
8. Teletherapy does not provide emergency services. If I am experiencing a medical emergency, I understand I can call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255) for free 24 hour hotline support. I acknowledge

that clients that are actively at risk of harm to self or others are not suitable for teletherapy services. If this is the case or becomes the case in the future, my therapist will recommend more appropriate services.

9. Other, unforeseen circumstances may occur through the course of treatment that may determine that teletherapy is not the most beneficial model of service. This will be assessed ongoing through teletherapy treatment by both myself and my therapist, and alternative options will be discussed if deemed appropriate and necessary.
10. I understand that the dissemination of any personally identifiable images or information from the teletherapy to other entities shall not occur without my written permission, aside from reasons outlined in discussions and forms discussed with my therapist (eg. suicidal/homicidal statements).
11. The email and cell phone number(s) below will be the only contacts that notices (invitations to teletherapy sessions) will be sent to. Should I need to change my email or phone number with my therapist, I will do so at least 48 hours prior to the scheduled appointment time and update this consent form for documentation in my chart.
12. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

I have read, understand and agree to the information provider regarding teletherapy.

Signature of consumer: _____ Date: _____
(14 and older)

Please print name: _____

Signature of Guardian: _____ Date: _____
(Required if consumer is under 18 years old)

Please print name: _____

Approved email: _____

Approved cell phone(s): _____

Therapist's Signature: _____ Date: _____

Restoring Balance Counseling, LLC

Teletherapy Emergency Contact Release of Information

CLIENT:

_____ _____
(Name of client) (D.O.B.)

_____
(Street Address)

_____
(City, State, Zip Code)

I HEREBY AUTHORIZE:

_____
(Name of Emergency Contact)

_____
(Street Address)

_____
(City, State, Zip Code)

_____
(Phone Number)

[X] **exchange all necessary verbal and/or written PHI (personal health information) with:**

Restoring Balance Counseling, LLC, 110 W. Linden Dr., Jefferson, WI 53549

which may include:

Assessment	Psychosocial Evaluation	Concerns about current or future risk
Continuing Care Plan	Demographic Information	Treatment Plan, Update or Summary
Diagnosis	Presence/Participation in Treatment	Other _____

Purpose of Release is to Coordinate Care with Emergency Contact.

Expiration: Unless sooner revoked, this authorization expires on the following date: _____ or as otherwise indicated: Upon termination of all services provided by Restoring Balance Counseling, LLC .

Notices:

Revocation: I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Restoring Balance Counseling, LLC, 110 W Linden Dr., Suite B, Jefferson, WI 53549. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Conditions: I further understand that Restoring Balance Counseling, LLC will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may have the following consequences: termination of teletherapy services with Restoring Balance Counseling, LLC .

Form of Disclosure: Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to verbally, in paper format, or electronically.

Redisclosure: I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is stricter than HIPAA and provides additional privacy protections.

_____ _____
Client Signature or Person Authorized to Consent Date

_____ _____
Signers Name (if signed by representative rather than client) Signer's Authority

(If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.)

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