LIGHTHOUSE COUNSELING SERVICES, PLLC

TELEHEALTH INFORMED CONSENT FORM

I consent to engaging in telehealth with Lighthouse Counseling Services as a part of the therapy process and my treatment goals. I understand that telehealth psychotherapy will be arranged prior to sessions, preferably 24 hours in advance, and at the therapist's discretion. I understand that telehealth services may not be as complete as in-person therapy services.
Telehealth will occur primarily through GoToMeeting, a HIPAA compliant interactive audio and video program.

I understand that the sessions need to be conducted at home, in a private setting in order for the session to be effective. I agree that if these sessions are not conducted in a private setting, the session will be cancelled, and I will be charged a $45 fee rather than utilizing insurance.

I understand that my health insurance may not cover telehealth services and that I will be responsible for any costs for these services.

I understand the following rights and limitations 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. I understand I am responsible for payment of sessions prior to invoking this right.

I authorize and give consent to provide my credit card information over the phone. I authorize Lighthouse Counseling Services to charge my card for all services and this authorization will remain in effect until cancelled.

I authorize to charge my credit card above for services when my credit card is not present (i.e., when I forget to bring my co-pay, Telehealth services and no-show/late cancellation fees). I understand that my information will be saved, in a secure location, to file for future transactions on my account.

2) The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information released by me during the course of my sessions is generally confidential. There are both mandatory and permissive exceptions to confidentiality

including, but not limited to, reporting child and vulnerable adult abuse, expressed imminent harm to oneself or others, or as a part of legal proceedings where information is requested by a court of law. 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 Lighthouse Counseling Services that: the transmission of my personal information could be disrupted or distorted by technical failures. I am aware of these issues and I will not hold Lighthouse Counseling Services or its staff liable.

4) I understand that certain situations including emergencies and crises are inappropriate for telehealth-based therapy services. If I am in a crisis or an emergency, I will immediately call 911 or go to the nearest hospital or crisis facility. I may contact the UNI Crisis Line at 801 587 3000. An emergency or crisis may include thoughts of hurting myself or others, engaging in self harm behaviors, or are in a life-threatening situation. I acknowledge I have been told that if I feel suicidal I am to call 911, local crisis agency UNI at 801 587 3000 or the National Suicide Hotline at 1 800 784 2433.

Client's signature_____

Date:_____