The Counseling Shop

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Telehealth Informed Consent Form

I _____, consent to engaging in telehealth with The Counseling Shop and my provider, specifically, as a part of the therapy process and my treatment goals. I understand that teletherapy psychotherapy may include mental health evaluation, assessment, consultation, treatment planning and therapy. Telehealth will occur primarily through interactive audio, video, telephone and/or other audio/video communications.

Technology: I understand that I will need to download an application and/or software to use this platform. I also need to have a broadband Internet Connection or a smartphone device with a good cellular connection at home or at the location deemed appropriate for services. I understand I do need to take precautions on my end to ensure privacy in the setting I choose to engage in telehealth appointments. I further understand my provider will be providing me a link to a secure platform within doxy.me to engage in services and my provider will ensure HIPAA compliance and security from the location they are engaging in services. All attempts to keep information confidential while using this secured system will be made but a guarantee of 100% confidentiality cannot be made with inherent issues with the communication systems.

I also understand that in case of technology failure, I may contact my provider via phone to coordinate alternative methods of treatment.

I understand that using the Telemedicine platform allows access to mental health services that might not otherwise be available to me due to my mental health, and/or my physical, resource, or geographic limitations.

Scheduling: I understand that scheduling is conducted through my provider and is based on my provider's normal clinic hours. Telemedicine appointments are considered outpatient services and are not intended as a substitute for emergency or crisis services. Crisis or mental health emergencies should be directed to the local county crisis line or dialing 911.

I understand I have the following rights 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, nor endangering the loss or withdrawal of any program benefits to which I would otherwise be eligible.

2. The laws that protect the confidentiality of my personal information also apply to telehealth. As such, all the limitations to confidentiality previously reviewed in our Informed Consent remains true for telehealth services. 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 The Counseling Shop that: the transmission of my personal information could be disrupted or distorted by technical

failures and/or the transmission of my personal information could be interrupted by unauthorized persons.

4. Engaging in telehealth requires your practitioner to be informed of your location prior to starting each session, in addition to ensuring the confidentiality of surrounding (i.e., practitioner is to be notified or made aware if anyone else is in the room).

5. Sessions are not to be recorded without the consent of the practitioner.

In addition, I understand that telehealth based services and care may not be as complete as in-person services. I understand that if my therapist believes I would be better served by other interventions, I will be referred to other mental health professionals who can provide those services in my area. I also understand that there are potential risks and benefits associated with any form of mental health treatment, and that despite my efforts and efforts of my therapist, my condition may not improve, or may have potential to get worse.

1. I understand that I may benefit from telehealth services, but that results cannot be guaranteed or assured. I understand that the use of doxy.me and audio/video systems are not 100% secure and may have wifi issues with these communication systems. Signing this form shows an awareness of these issues and a decision by this client to use these systems for telehealth services. I will not hold The Counseling Shop or staff for gathering or use of client information by these service providers.

2. By signing this document I agree that certain situations including emergencies and crises are inappropriate for audio/video/computer based psychotherapy services. If I am in crisis or in an emergency I should immediately call 911 or go to the nearest hospital or crisis facility. By signing this document I understand that in an emergency situation may include thoughts about hurting or harming myself or others, having uncontrolled psychotic symptoms, if I am in a life threatening or emergency situation, and/or if I am abusing drugs or alcohol and are not safe.

3. By signing this document, I acknowledge I have been told that if I feel suicidal I am to call 911, local county crisis agencies or the National Suicide Hotline at 1-800-784-2433.

_____ _____

Signature of client/parent/guardian Date

_____ _____

Printed name of client/parent/guardian Relationship (if applicable)

_____ _____

Signature of Provider Date