Avis Augustine-Miller, LPC, LMHC
1120 McConville Rd., Suite A, Lynchburg, VA 24502
Phone (434) 421-5161
Fax (434) 237-4084
avis@distinctivelyyoursllc.org
www.DistinctivelyYoursLLC.org

Telehealth Informed Consent Form

I _____, consent to engaging in telehealth with Avis Augustine-Miller dba Distinctively Yours, LLC Counseling and Consulting as a part of the therapy process and my treatment goals. I understand that telehealth 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.

Telehealth refers to psychotherapy services that occur via phone, email, or synchronous video conferencing. All of our interactions will fall under this term. When using technology, there is always the risk of security issues, as well as technical issues (phone not charged, computer or software not working, etc.). You will develop an individualized plan for how best to address technical issues that may arise and will take steps to facilitate the security of interactions with your therapist. In addition to the identified risks, there are several benefits that come from using technology. For instance, it allows therapists to connect with people who may otherwise not be able to access services, there is an opportunity for more flexibility in scheduling, and convenience in being able to connect from a space of your choosing. In order to protect your confidentiality and to facilitate the security of your information as much as possible, here is a list of recommendations:

* Engage in sessions in a private location where you cannot be heard by others.

* Use a private smartphone or computer with a webcam to protect your information during session.

* Do not record your sessions which risks someone finding and listening to them and breaking your confidentiality. Sessions should not be recorded without the consent of both parties; therapist and client.

* Password protect any technology that you use to interact with your therapist.

* Always log out or hang up once sessions are complete. If you share a computer, clear the cache also. In addition, ensure that your internet connection is secure and private for the protection of your personal health information. Public/free WIFI is not secure and your information is not protected.

Client Name: _____ DOB: _____

* To avoid others knowing we have connected, your therapist will be expecting you to enter the waiting room from the link sent to you via email, once you are in a private place.

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, 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 Avis Augustine-Miller dba Distinctively Yours, LLC Counseling and Consulting 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.

   In addition, I understand that telehealth based services and care may not be as complete and in-person services. I understand that if my therapist believes I would be better served by other interventions I will be referred to a mental health professional 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 the efforts of my therapist, my condition may not improve as expected, or may have the potential to worsen. In that event, my therapist will refer me to the nearest emergency room and then refer me to a professional in my area.

4) 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, which although not 100% secure, is HIPAA compliant and one of the most secure telehealth platforms available. I understand that there may be issues with WIFI connectivity on either side of the conversation at times. All attempts to keep information confidential while using these systems will be made but a guarantee of 100% confidentiality cannot be made with inherent 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 Avis Augustine-Miller dba Distinctively Yours, LLC Counseling and Consulting or its staff liable for gathering or use of client information by these service providers. In the event that connectivity issues cannot be resolved during session, parties will reconnect by telephone.

5) I understand I have the right to access my personal information and copies of case notes. I have read and understand the information provided above. I have discussed these points with my therapist, and all of my questions regarding the above matters have been answered to my approval.

6) 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 emergency department or crisis facility. By signing this document I understand that emergency situations may include thoughts about hurting or harming myself or others, having uncontrolled and/or sudden onset psychotic symptoms, if I am in a life threating or emergency situation, and/or if I am abusing drugs or alcohol and I am not

Client Name: _____ DOB: _____

safe. By signing this document, I acknowledge I have been told that if I feel suicidal I am to call 911 and ask for a CIT Trained officer, or the nearest Behavioral Health Agency/Community Services Board Emergency Services team at _____, 24 hours/day or the National Suicide Hotline at 1-800-784-2433. I can also text CONNECT to 741741 to contact the National Suicide Prevention Hotline. Added to these are two close contacts that I can reach out to.

Name of Contact: _____ Tel #: _____

Name of Contact: _____ Tel #: _____

7) I understand that the fee for my therapy, sessions is the agreed upon hourly rate and will be paid at the beginning of every session. I also understand that cancellation of a session must be made 24 hours before the session or a cancellation fee equivalent to the cost of the session will be charged.

8) Email, phone calls and text messaging will be the main forms of contact with your therapist. Please be vigilant about leaving messages so that no confidential information is intercepted. If you need to speak with your therapist, please leave a text message or an email indicating that you need a return call and one will be made within 24 hours at the soonest opportunity to protect your privacy.

Authorization of Treatment

I, _____ authorize evaluation and treatment from Avis Augustine-Miller dba Distinctively Yours, LLC Counseling and Consulting. I acknowledge that I may request a copy of this informed consent agreement. It is agreed that either of us can discontinue treatment at any time.

Signature of client/parent/guardian Date

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

Client Name: _____ DOB: _____