Teletherapy Agreement & Informed Consent

1. You understand that teletherapy includes consultation, treatment, transfer of medical data, emails, telephone conversations, and education using interactive audio, video, or data communications; that teletherapy also involves the communication of your medical/mental health information, both orally and visually.

2. Unless we explicitly agree otherwise, our teletherapy exchange is strictly confidential. Any information you choose to share with me will be held in the strictest confidence. As with face-to-face counseling, I will not release your information to anyone without your prior approval unless I am required to do so by law. In Kentucky, we are required to notify authorities if we become convinced a client is about to physically harm someone, is a threat or harm to themselves, or if they are abusing or about to abuse children, the elderly, or the disabled.

3. You understand that our teletherapy services are furnished in the state of Kentucky, (USA), and the services provided are governed by the laws of that state. In a manner of speaking, you are using this modality to visit/conduct counseling in a Kentucky office, where we meet to do our work.

4. You have the right to withdraw or withhold consent from teletherapy services at any time. You also have the right to terminate treatment at any time.

5. You understand that there are risks and consequences with teletherapy services including, but not limited to, the possibility, despite reasonable efforts on my part, that: the transmission of your medical information could be disrupted or distorted by technical failures; the transmission of your information could be intercepted by unauthorized persons, and/or the electronic storage of your medical information could be accessed by unauthorized persons.

6. In addition, you understand that teletherapy based services and care may not be as complete as traditional face-to-face services. While teletherapy is an effective medium for many presenting concerns, overwhelming and potentially dangerous concerns are best met with face-to-face professional support. You understand that teletherapy is neither a universal substitute, nor the same as face-to-face psychotherapy. If I believe that your needs would best be served by a local professional, you will be referred to a professional who can provide such services in your area. Finally, you understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts or the efforts of any such provider, your condition may not improve, and in some cases may even get worse.

7. You understand that you may benefit from teletherapy, but that results cannot be guaranteed or assured.

8. You understand and accept that teletherapy does not provide emergency services. If you are experiencing an emergency, you understand that the protocol is to call 911 or proceed to the nearest

hospital emergency room for help. If you are having suicidal thoughts or making plans to harm yourself, agree to call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255) for free 24-hour hotline support.

9. You will be responsible for the following: (1) providing the computer and/or necessary telecommunications equipment and internet access for your teletherapy sessions, (2) securing or encrypting protected health information (PHI) transmitted to or stored on your computer/telecommunications device, (3) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for your teletherapy sessions, (4) sessions are not recorded or observed by any person without prior written consent.

10. You understand that while email may be used as a form of communication, that confidentiality of emails cannot be guaranteed due to complexities and abnormalities involved with the Internet, including, but not limited to, viruses, Trojans, worms, and other involuntary intrusions that have the ability to obtain and disseminate information you wish to keep private.

11. You have the right to access your medical information and copies of your medical records in accordance with HIPAA privacy rules and applicable state law.

12. You are required to reside in the state in which your therapist or therapist's supervisor holds professional license.

I have read and understand the information provided above. I have discussed it with my counselor, and all my questions have been answered to my satisfaction.

_____

Signature of client or client representative (parent, guardian, or other authorized signatory Date

_____

Printed name Relationship if not self

_____

Email address Alt phone number