



## INFORMED CONSENT FOR TELEHEALTH COUNSELING

*Please read this document, initial the following statements, sign the last page, and return at your first appointment.*

\_\_\_\_ I understand that my Counselor has agreed to conduct therapy through Telehealth consultations with me, and that while Telehealth/ Distance Counseling offers benefits such as Client convenience and accessibility, it also comes with several limitations and risks, including:

- **Interruptions to the Counseling session, unauthorized access, and technical difficulties or failures.** If this occurs, either the Counselor or the Client can discontinue the Telehealth consult/ visit if it is felt that the videoconferencing connections are not adequate for the situation. The appointment may be rescheduled at another time.
- **Potential limitations and exceptions to the Client's privacy** such as details of Client's medical history and personal health information being discussed and transmitted with the use of interactive video, audio, or other telecommunications technology.
- Potential barriers to the transmission of Personal Health Information, paperwork, and some Counseling Interventions, thus they are likely to be transmitted through email or postal mail.
- Limits to the Counselor's ability to observe changes in the Client's moods and cognitive processes and limitations to the Counselor's ability to provide certain therapeutic interventions that are more readily administered through In-person Counseling sessions
- The Counselor may determine that Telehealth counseling is not adequate or appropriate to treat the Client's mental health condition and needs therein- and may therefore recommend that Client seek treatment with other qualified mental health professionals in my geographic location. The Client may request that the Telehealth Counselor provide referrals to qualified providers and it will be the Client's responsibility to contact those referrals and initiate a transfer of services.

\_\_\_\_ Payments are processed through an online EHR portal such as 'Headway'. Clients are required to provide accurate credit card information and or HSA card information for billing purposes, since payments are due at the time that services are provided. The Client is encouraged to contact their insurance provider and inquire about Telehealth services or mental health out-of-network benefits, regarding deductibles and any copay amounts, etc.

\_\_\_\_ Telehealth sessions typically last for 53-60 minutes. If the Client is 10+ minutes late, the Counselor has the right to consider the session a 'no-show' and charge the full session fee, counting as a missed appointment.

\_\_\_\_ I agree that if I am not able to attend the Telehealth counseling session, I will provide an early notification to my Therapist of **at least 32 hours advanced notification. Otherwise, I may be charged a late cancellation fee of the full session fee amount** and that amount will not be covered by my insurance provider.

\_\_\_\_ All Client communications (phone calls, emails, text messages) become part of your clinical record and is confidential, except in the following cases:

- It is determined that you are a danger to yourself or others, or in the case of an Emergency
- You disclose abuse, neglect, or exploitation of a child, elderly or disabled person
- You direct me to release your records
- I am required by law, or Court order to disclose information
- In the case of billing or collection fees
- Any other exceptions authorized by law

\_\_\_\_ In the event of a high-risk or emergency situation (i.e. Client with suicidal or homicidal ideation), the Counselor has the right to contact the Client's Emergency Contact, notify authorities, and collaborate with other licensed medical professionals in an effort to ensure safety.

\_\_\_\_\_ The Counselor may engage in periodic Peer consultation (a process of case review with other professional, objective colleagues) to ensure quality counseling. No patient names or identifying information will be used, to ensure Client confidentiality.

\_\_\_\_\_ The technology systems used for electronic health records, billing and Telehealth service transmissions by the Counselor have been selected and arranged to protect Client privacy through network and software security protocols that safeguard data transmissions against intentional or unintentional corruption. However, there are still potential risks for privacy or data breach.

\_\_\_\_\_ Our Telehealth sessions will be conducted through my Therapists's professional subscription to "Google Meet", a secure, HIPAA compliant technology platform. I am aware that my Counselor is not always available for phone call, text, or email- and that Google Meet is not an Emergency mental health or medical service. Google Meet only facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care. Also, I do not assume that my provider has access to any or all of the technical information about Google Meet, or that such information is accurate or up to date- AND I will not rely on my Therapist to have any of this information.

\_\_\_\_\_ I acknowledge that I will receive the specific link for each Telehealth session through "Google Meet" as a Google Calendar invite and that I will receive notifications of the appointment via Google Calendar and also from Headway. It is my responsibility to keep account of my sheduled appointments and scheduled times for meetings.

\_\_\_\_\_ If for any reason you as the Client are dissatisfied with your Counselor's services, please discuss this right away, so that a suitable solution can be found. If we are not able to resolve your concerns, or you feel that an ethical standard has been violated, you may file a complaint in writing to: the Texas Board of Examiners of Professional Counselors, Complaints Management and Investigative Section, P.O. Box 141369, Austin, TX 78714-1369 or by calling 1-800-942-5540.

## **CLIENT RESPONSIBILITIES**

\_\_\_\_\_ Client agrees to complete all Intake documents and provide payment information as credit card prior to first Telehealth counseling appointment AND to show a valid driver's license, passport, and state issued ID at our first session and to provide verbal identification for myself thereafter.

\_\_\_\_\_ Client agrees to create a safe and confidential atmosphere that is free of other people and distractions, to maintain privacy during Telehealth sessions, and to show surroundings to the therapist, if asked. Client also agrees not to share the Telehealth appointment link or other details with anyone who is unauthorized to attend the appointment.

\_\_\_\_\_ Client agrees NOT to record video or audio sessions without Therapist's permission or consent. Your therapist will not record video or audio sessions.

\_\_\_\_\_ Client agrees that In the event of an emergency, to call 988, and or to go to nearest hospital Emergency Room which is located at \_\_\_\_\_,

\_\_\_\_\_ As the Client, I agree that, If there is a disruption or interruption of Service, I will resume contact with the Counselor by calling or texting her at 214-494-1990; the session may continue as a phone call if the video technology fails. My therapist and I will communicate by phone call. I prefer that my Therapist contact me by phone at: \_\_\_\_\_.

**INFORMED CONSENT FOR TELEHEALTH COUNSELING**

\*\*\* BY SIGNING BELOW I CONFIRM THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT. I AGREE THAT ALL OF MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION. I CONSENT FOR MYSELF OR MY MINOR CHILD TO RECEIVE COUNSELING SERVICES WITH Amy Burley, LPC (of Hope Dynamics Counseling, LLC). I CERTIFY THAT I HAVE THE LEGAL RIGHT TO SEEK AND AUTHORIZE TREATMENT FOR MYSELF AND/OR MY MINOR CHILD.

Client Name: \_\_\_\_\_

Signature of Client or Parent/ Guardian: \_\_\_\_\_

Date of Signature: \_\_\_\_\_