SULLIVAN COUNSELING Telehealth INFORMED CONSENT FORM

I, _____, (client name) hereby consent to participate in Telehealth with, _____ , (therapist name) as part of my psychotherapy. I understand that Telehealth is the practice of delivering clinical mental health care services via communications technology (e.g. internet or phone) between a practitioner and a client who are located in two different locations.

By signing this form, I understand and agree to the following:

1. I have a right to confidentiality with regard to my treatment and related communications via Telehealth under the same laws that protect the confidentiality of my treatment information during in-person psychotherapy. The same mandatory and permissive exceptions to confidentiality outlined in the Informed Consent Form or Statement of Disclosures I received from my therapist also apply to my Telehealth services.

2. I understand that there are risks, benefits, and consequences associated with Telehealth, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

3. I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

4. I understand that there is a risk of being overheard by persons near me and that I am responsible for using a location that is private and free from distractions or intrusions.

5. I understand that at the beginning of each Telehealth session my therapist is required to verify my full name and current location.

6. I understand that in some instances Telehealth may not be as effective or provide the same results as in-person therapy. I understand that if my therapist believes I would be better served by in-person therapy, my therapist will discuss this with me and refer me to in-person services as needed. If such services are not possible because of distance or hardship, I will be referred to other therapists who can provide such services.

7. I understand that while Telehealth has been found to be effective in treating a wide range of mental and emotional issues, there is no guarantee that Telehealth is effective for all individuals. Therefore, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.

8. I have discussed the fees charged for Telehealth with my therapist and agree to them. I have discussed with my therapist and agree that my therapist will bill my insurance plan for Telehealth and that I will be billed for any portion that is the client's responsibility (e.g. co-payments), and I have been provided with this information in the Informed Consent Form or Name of Payment Agreement Form.

9. I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that Telehealth services are not appropriate and a higher level of care is required.

10. I understand that my therapist will make reasonable efforts to ascertain and provide me with emergency resources in my geographic area. I further understand that my therapist may not be able to assist me in an emergency situation. If I require emergency care, I understand that I may call 911 or proceed to the nearest hospital emergency room for immediate assistance.

11. I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

Emergency Protocols

I need to know your location in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life-threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

In case of an emergency, my location is: _____ and

my emergency contact person's name, address, phone:

_____

_____

I have read and understand the information provided above, have discussed it with my therapist, and understand that I have the right to have all my questions regarding this information answered to my satisfaction.

For conjoint or family therapy, clients may sign individual consent forms or sign the same form.

_____ _____

Signature of client/parent/legal guardian Date

_____

Client's Printed Name

Verbal Consent Obtained

Therapist reviewed Telehealth Consent Form with client, client understands and agrees to the above advisements, and client has verbally consented to receiving psychotherapy services from Therapist via Telehealth.

_____ _____

Therapist's Signature Date