 **TELEHEALTH INFORMED CONSENT**

This Informed Consent is intended to inform you about Union Family, PLLC’s policies and procedures regarding Telehealth Services and to ensure your agreement to these services. Your signature indicates that you, the client, have acknowledged that you understand and agree that Union Family, PLLC will provide therapy to you according to this Telehealth Informed Consent Form. The content below must be read, discussed with your therapist at the initial consultation (and any time thereafter as needed) OR before the start of any Telehealth Services, and agreed upon before any Telehealth Services can begin. Please ensure that each section is read and reviewed carefully. If you have any questions, please discuss them with your therapist before obtaining any Telehealth services.

I understand that Telehealth (also referred to as e-therapy, teletherapy, telemedicine, virtual teletherapy or video therapy) is the use of HIPAA compliant electronic information and communication technologies (including video and audio technology) by a mental health provider to deliver services to an individual when they are located at a site that is different than their provider.

I understand that the Health Insurance Portability and Accountability Act (HIPAA) policies and laws that protect the privacy and confidentiality of my medical information also applies to Telehealth. My rights to confidentiality with Telehealth services are exactly the same as my rights for in-person therapy services.

There are also limits to confidentiality as dictated by law. Any information disclosed by me during the course of my therapy, therefore, is generally confidential with the exception of the following:

• Mandatory reporting of child, elder, and dependent adult abuse.

• Any threats of violence made towards a reasonably identifiable person.

• If I am in such a mental or emotional condition to be a danger to myself or others, my therapist has the right to break confidentiality to prevent the threatened danger.

• Under court order or subpoena, the provider may be required to disclose information to person(s) as directed by the order or subpoena.

• If an investigation is being conducted by a licensing board or other government entity, information may be disclosed as directed by that board or entity.

Therapeutic treatment for mental health, both in person and through Telehealth services, has been found to be effective in treating a wide range of clients. Individual results and responses to therapy may vary. By signing this form, I also understand that results of any therapy, whether in person or through Telehealth services, cannot be guaranteed.

I further understand that there are risks unique and specific to Telehealth, including but not limited to, the possibility that our therapy sessions or other communication by my therapist to others regarding my treatment could be disrupted or distorted by technical failures, could be interrupted, or could be accessed by unauthorized persons. If a disruption or an emergency situation occurs, my therapist at Union Family, PLLC can be contacted by phone. By signing this consent form, I am indicating that I know how to contact my provider in case of disruption or emergency. I understand that my provider must utilize a HIPAA compliant platform to provide Telehealth, and that FaceTime and Skype are not HIPAA compliant programs and therefore not available as an option to use. I understand that my provider will provide me with information for accessing the HIPAA compliant platforms.

I understand that Telehealth treatment for mental health is different from in-person therapy. I understand that if my therapist believes I would be better served by another form of therapeutic treatment or services, such as in-person treatment, I will be provided a referral to another therapist who can provide me with recommended services, such as in person therapy.

Additionally, I understand that the capture (including screenshots or photos of the therapy session), saving, or dissemination of any personally identifiable images or information from the Telehealth interaction to any other entities shall not occur without my and my therapists explicit written consent. Union Family, PLLC also agrees to under no circumstances take any personally identifiable images from the session or store any of these images on her own devices from Telehealth sessions.

I also understand that my Telehealth appointment time is reserved exclusively for me. As with my in-person appointments, if I cannot attend my scheduled Telehealth appointment, I will contact my therapist directly at least 24 hours before the session start time to reschedule. If I do not provide 24 hour notice for non-emergency reasons the following cancelation fees will apply. Similarly, if I am late to my scheduled session, I will receive my services for the remainder of my scheduled session time slot without refund.

• Late fee: late cancelation $75. • No shows are a $75 charge.

Also, due to certain licensing requirements I agree to be physically in North Carolina each session and to give my current physical address accurately at the beginning of each session. I also agree to tell my therapist at the beginning of each session if I am having any suicidal or homicidal thoughts.

I understand that Telehealth appointments need to be conducted in a private and confidential space. I agree (unless otherwise agreed upon) to conduct my appointments in a private and secure room where I am the only one present. I will be prepared to do a “room scan” to ensure that I am the only one in the room. I also agree to ensure security on my device used for Telehealth, including not sharing my password or login information with anyone, and logging out of programs used for sessions at the completion of the session.

In the case that the client is a minor child, the child’s parent or guardian agrees to help support their child in finding a confidential and private space. The parent also agrees to be either physically present at the location OR available via phone for the duration of the session and 15 minutes prior and after the scheduled session time. The parent must be willing and able to join the session at any time if requested.

I understand that I have the right to withhold or withdraw my consent to use Telehealth services in the course of my care at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting my therapist at Union Family, PLLC.

I have fully read, understand, and agree to comply with the information provided above. I understand I have the right to discuss any of this information with my therapist and to have any questions I may have regarding my treatment answered to my satisfaction.

I have reviewed the **TELEHEALTH INFORMED CONSENT**. My signature indicates I understand and agree to the consent. I have been offered a copy.

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 If signing, please note relationship to client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_