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### **Informed Consent for Telehealth Services**

The following information is provided to clients who are seeking Telehealth therapy. This document covers your rights, risks and benefits associated with receiving services, my policies and your authorization. Please read this document carefully, note any questions you would like to discuss and sign.

#### **Telehealth Services Defined:**

Telehealth Services means the remote delivering of counseling, Parent Facilitation, or Parent Coordination services via technology-assisted media. This includes a wide array of clinical services and various forms of technology. The technology includes but is not limited to video, internet, a smartphone, tablet, PC desktop system or other electronic means. The delivery method must be secured by two-way encryption to be considered secure. Synchronous (at the same time) secure video chatting is the preferred method of service delivery.

#### **Limitations of Telehealth Services:**

While Telehealth Services offers several advantages such as convenience and flexibility, it is an alternative form of therapy, Parent Facilitation, or Parent Coordination, or adjunct to therapy, Parent Facilitation, or Parent Coordination and thus may involve disadvantages and limitations. For example, there may be a disruption to the service (e.g. phone gets cut off or video drops). This can be frustrating and interrupt the normal flow of personal interaction. Primarily, there is a risk of misunderstanding one another when communication lacks visual or auditory cues. For example, if video quality is lacking for some reason, I might not see various details such as facial expressions. Or if audio quality is lacking, I might not hear differences in your tone of voice that I could easily pick up if you were in my office.

Additionally, my office decreases the likelihood of interruptions. However, there are ways to minimize interruptions and maximize privacy and effectiveness. As a Mental Health Professional will take every precaution to insure technologically secure and environmentally private sessions.

#### **Client Responsibilities for Telehealth Services:**

1. The virtual sessions can only be conducted while the client is within the state of Texas.
2. The virtual sessions must be conducted on a Wi-Fi connection for the best connections and to minimize disruption.
3. Only communicate through a device that you know is safe and technologically secure (e.g. has a firewall, anti-virus software installed, is password protected, not accessing the internet through a public wireless network, etc.) Do not use "auto-remember" names and passwords.
4. If conducting a Telehealth session at your place of employment, make sure you have checked your company's policy before using a work computer for personal communication.
5. As the client, you are responsible for finding a private, quiet location where the sessions may be conducted.
6. **Sessions are not able to take place if other individuals are present in your location.**
7. **Identity and Location:** I am required to verify your identity and location at the start of each session.

**In Case of Technology Failure:**

I understand that during a Telehealth session, we could encounter a technological failure. Difficulties with hardware, software, equipment, and/or services supplied by a 3<sup>rd</sup> party may result in service interruptions. If something occurs to prevent or disrupt any scheduled appointment due to technical complications and the session cannot be completed via online video conferencing, please call the back at 817-483-0020, Please make sure you have a phone with you and that I have that phone number. I may also reschedule if there are problems with connectivity.

**Interactive Video, Electronic Medical Record, Secure Email for Documents:**

I utilize Zoom Telehealth for interactive video which includes support 248-bit AES encryption for all signaling.

**I agree to take full responsibility for the security of any communications or treatment on my own computer or electronic device and in my own physical location.** I understand I am solely responsible for maintaining the strict confidentiality of my user ID, password, and/or connectivity link. I shall not allow another person to use my user ID or connectivity link to access services. I also understand that I am responsible for using this technology in a secure and private location so that others cannot hear my conversations.

**I understand that there will be no recording of any of the online sessions and that all information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without my written permission, except where disclosure is required by law.**

**Consent for Telehealth Services Treatment:**

I voluntarily agree to receive online therapy , Parent Facilitation, or Parent Coordination services for an assessment, continued care, treatment, or other services and authorize Carol Mapp, LCSW to provide such care, treatment or services as are considered necessary and advisable. I understand and agree that I will participate in the planning of my care, treatment or services and that I may withdraw consent for such care, treatment or services that I receive at any time. By signing this Informed Consent, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

Please know that I have the utmost respect and positive regard for you and your well-being. I invite you to keep our communication open at all times to reduce any possible harm. Please use technology with discretion. Only communicate limited information such as appointment requests, cancellations or estimated times of arrival.

\_\_\_\_\_  
Patient/Client Signature

\_\_\_\_\_  
Parent/Guardian/Legal Representative Signature *(if minor or needed otherwise)*

\_\_\_\_\_  
Professional's Signature

Date\_\_\_\_\_