ASPIRE
COUNSELING GROUP

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Informed Consent to Telehealth

Addendum to Consent for Services

Telehealth has the same purpose or intention as psychotherapy or psychological treatment sessions that are conducted in person. However, due to the nature of the technology used, I understand that telehealth may be experienced somewhat differently than face-to-face treatment sessions. I understand that I have the following rights with respect to telehealth:

1. I understand that at times telehealth may be a viable form of treatment my therapist and I may discuss to promote continuity of care when I cannot physically be present in my therapist's office due to several factors, including but not limited to: travel for work, recovering from an illness and not being able to travel, lack of access to transportation to the office, return to college, when weather advisories that make it unsafe to travel, etc.
2. I understand that telehealth is an option in which my therapist and I may use the internet on various devices, computer, tablet, phone, and will be able to see and hear each other and interact in real time to engage in psychotherapy.
3. I understand that the policy at Aspire Group Counseling is to use secure platforms like Doxy.me or Google Meet (both of which are free) whenever possible. Both are encrypted to the federal standard, are HIPAA compliant and have signed a HIPAA Business Associate Agreement--attesting to HIPAA compliance. Both platforms are responsible for keeping any videoconferencing confidential and secure. I understand that Skype, FaceTime, and other platforms are not as secure and there is a risk that private healthcare information may be breached.
4. I understand that when I am engaged in telehealth psychotherapy, it is my responsibility to choose a secure location to ensure that family, friends, employers, co-workers, strangers, or hackers cannot overhear my communications or have access to the technology or devices I am using.
5. I understand that, on my end, it is my responsibility to make sure that I am using a private and encrypted WiFi, (never a public WiFi) and that my devices have protections like firewalls, anti-virus software and are password protected. I understand that my therapist is using the same standards on their devices to protect my privacy and confidentiality.
6. I understand that my therapist may only use telehealth in states where they are licensed even though I may be in other locations. For example, I understand that only clinicians licensed to practice in North Carolina, per the law, may practice therapy in North Carolina.
7. I understand that most insurances now cover some form of telehealth and that my therapist will have my benefits checked as a courtesy, but it is, ultimately, my responsibility to know whether or not my insurance company covers telehealth sessions. In the event that insurance does not cover telehealth and I wish to pay out-of-pocket or when there is no insurance coverage, a prompt pay discount may be available. At my request, my therapist will provide a statement to submit to my insurance company.
8. I understand there may be risks to telehealth psychotherapy, including but not limited to: poor internet connections, technical difficulties, power failures in the middle of a session, etc.
9. I understand that if there is a loss of transmission, my therapist will call me on the phone to complete the session. Sometimes phone sessions are not covered by insurance--there may be a private fee assessed for any part of a session that has to be completed via phone.

10. I understand that I can discontinue telehealth psychotherapy sessions and revoke this authorization at any time without affecting my right to future care or treatment. I also understand that my therapist has the right to discontinue telehealth sessions at any time if it becomes apparent that face-to-face treatment with the therapist would be more appropriate.
11. I understand that I may benefit from telehealth psychotherapy sessions, but that results cannot be guaranteed nor assured.
12. I accept that telehealth is not an emergency service. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) for free 24-hour hotline support.

    Clients who are actively at risk of harm to self or others are not suitable for telehealth services. If this is the case or becomes the case in future, my clinician will recommend more appropriate services.
13. I understand that dissemination of any personally identifiable images or information from the telehealth interaction to researchers or other entities shall not occur without my written consent.
14. I understand that this informed consent for telehealth psychotherapy is only in addition to my informed Consent for Services and does not replace it.

Emergency Protocols:

Your therapist needs to know your location in case of an emergency. I agree to inform my therapist of the address where I am located at the beginning of each session. My therapist also needs a contact person who they may contact on my behalf in a life-threatening emergency only. This person will only be contacted to go to my location or take me to the hospital in the event of an emergency.

In case of an emergency, my location address is:

Street address: _____

City/state/zip: _____

Phone: _____

Please check your location:

☐ Home ☐ Work (please indicate name): _____

☐ Other (specify): _____

Emergency Contact's Information:

Emergency contact name: _____

Relationship: _____

Street address: _____

City/state/zip: _____

Phone: _____

By signing this form, I certify:

a. That I have read or have had this form read and/or had this form explained to me.

b. That I fully understand the risks and benefits of telehealth psychotherapy.

c. That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Name (printed): _____

Client signature: _____

Date: _____

Therapist name (printed): _____

Therapist signature: _____

Date: _____