PREMIERE COUNSELING PROFESSIONALS, PLLC

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INFORMED CONSENT FOR TELEHEALTH SERVICES

TELEHEALTH SERVICES: As a client receiving telehealth services, I understand that telehealth is the delivery of behavioral health services using interactive technologies (use of audio, video or other electronic communications) between a practitioner and a client who are not in the same physical location. The interactive technologies used in teletherapy incorporate network and software security protocols to protect the confidentiality of client information transmitted via any electronic channel. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption. Confidentiality still applies for Telehealth services and nobody will record the session without the permission from the other person. I agree to be on time and should I need to cancel, I will follow the established protocol as it relates to method and timeframe.

TELEHEALTH AGREEMENTS: The sessions are to occur between the therapist and me, the identified client. I will be informed if any additional personnel or individuals are to accompany me and the provider and I will give verbal permission prior to the session. The therapist will maintain documentation of sessions, similar to those completed for in-office sessions. I will use my personal equipment and not that of others (e.g. employer) which could compromise my privacy. I agree to secure a quiet, private space that is free of distractions during the session. I understand that my healthcare information may be shared with others only in the cases of an emergency, for scheduling and/or billing purposes. My therapist and I will regularly reassess the appropriateness of continuing to deliver services to me through the use of the technologies we have agreed upon today, and modify our plan as needed. I understand I may decline teletherapy health services at any time without jeopardizing my access to future care, services and benefits. If I am an existing client, all other client agreements remain consistent with the signed Client Agreement on file.

TECHNOLOGY REQUIREMENTS: I will need access to, and familiarity with, the appropriate technology in order to participate in the service provided. The exchange of information will not be direct and any paperwork exchanged will likely be provided through electronic means or through postal delivery. I understand that I will receive a unique URL for each scheduled session. I will need a phone, tablet or computer with a webcam and microphone, a high-speed secure internet connection and access to a mobile browser (e.g. Google Chrome, Safari, Mozilla, Firefox). I understand that Premiere Counseling Professionals uses a HIPPA compliant teletherapy platform.

TECHNOLOGY RISKS: These services rely on technology, which allows for greater convenience in service delivery. There are risks in transmitting information over technology that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties, equipment failures or inadequate video quality. If the service is disrupted, the therapist will call me immediately to discuss a plan. I understand that the therapist may ask for a current phone number at the

start of each session. I understand that telehealth service delivery is emerging and there may be risks not yet identified.

EMERGENCY PROCEDURES SPECIFIC TO TELEHEALTH SERVICES: There are additional procedures that are in place specific to Telehealth services. I agree to inform you of the address where I am at the beginning of every session. These are for my safety in case of an emergency and are as follows: I understand that if I am having suicidal or homicidal thoughts, experiencing psychotic symptoms, or in a crisis that we cannot solve remotely, the therapist may determine that I need a higher level of care and Telehealth services are not appropriate. My therapist requires consent to contact an Emergency Contact Person (ECP) who she/he may contact on my behalf in a life-threatening emergency only. Additionally, if either my therapist, my ECP, or I determine necessary, the therapist or ECP will contact the local police and/or have me transported to my local hospital. My signature at the end of this document indicates that I understand my therapist will only contact this individual in the extreme circumstances stated above. I consent to sharing information provided here if needed in an emergency. Please list:

Emergency Contact Person (ECP):

Name: _____

Phone:_____

In addition, please list the nearest mental health hospital to your primary location in the event of a mental health emergency and the nearest police department and contact information.

Hospital Name: _____

Phone: _____

Local Police Department: _____

Phone:_____

I understand this form, consent to teletherapy, agree to use these procedures, and have completed the form in its' entirety. I acknowledge that I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction

Client Name (printed): _____ Date: _____

Signature:_____