TELEHEALTH INFORMED CONSENT

This Informed Consent form is intended to inform you about ***Embracing Hope Counseling & Family Services, PLLC*** policies and procedures regarding Telehealth Services and to ensure your agreement to these services. Your signature on this form indicates that you, the client, are acknowledging that you understand and agree that ***Embracing Hope Counseling & Family Services, 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. Please print a copy of this policy for your records and this policy can be available at any time if requested.

I understand that Telehealth (also referred to as e-therapy, teletherapy, telemental health, virtual therapy 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 Telemedicine. My rights to confidentiality with Telemedicine services are the same as my rights for in-person therapy services, including the limitations to confidentiality as dictated by law. Confidentiality and limits to confidentiality are outlined in the HIPAA Notice of Privacy Practices, which you received at intake and is also available online at embracinghopecounseling.com.

Therapeutic treatment for mental health, both in person and through Telemedicine 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 Telemedicine services, cannot be guaranteed.

I further understand that there are risks unique and specific to Telemedicine, 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 ***Angie Lutts, LCSW*** can be contacted at ***817-918-7300. By signing this consent form I am acknowledging that I know how to contact my provider in case of a disruption or emergency.***

I understand that Telemedicine 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, my therapist will inform me of this recommendation.

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 explicit written consent. **Angie Lutts, LCSW** 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 Telemedicine sessions.

I also understand that my Telehealth appointment time is reserved exclusively for me. If I cannot attend my scheduled appointment, I will contact my therapist directly at least 24 hours before the session start time to reschedule. In accordance with the Professional Disclosure Statement and Informed Consent for Services, if I do not provide 24 hour notice for non-emergency reasons, I understand a late cancellation fee of $50.00 will apply. It is important to note that insurance companies do not provide reimbursement for cancelled sessions.

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

In accordance with the American Telemedicine Association (ATA) I agree to have Telehealth sessions on a device that has a minimum bandwidth of 384 kilobits per second and a minimum live video display resolution of 640 x 360 pixels at 30 frames per second. You can test your speed at https://www.speedtest.net/. *These requirements mean that the speed and quality of video must be quick enough to have a meaningful conversation.*

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 present in the room.

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 the use of 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 ***Embracing Hope Counseling & Family Services, PLLC*** will at **817-918-7300.**

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.

My signature below indicates that I have read this Telehealth Informed Consent and agree to its terms. I hereby consent to participating in psychotherapy via Telehealth Services via an online HIPAA compliant telemedicine platform with Angie Lutts, LCSW:

Client Name (printed): _____
(or parent or legal guardian)

Client signature: _____
(or parent or legal guardian)

Clinician Signature: _____

Date (mm/dd/yy):_____