_____ Psychological Services Center Addendum
Consent to Telehealth Videoconferencing Services

The following information pertains specifically to the use of videoconferencing. Use of videoconferencing is completely voluntary and is an option you can discuss with your therapist if you are interested.

• The CLINIC will offer an online communication tool allowing for face-to-face video that is deemed to be HIPAA-compliant. For more information about the medium's security and privacy, please ask your therapist for more information.

• Appointments will be made via email, phone, or text.

• Please be online at least five minutes prior to session alone in a quiet room with the door closed. Please choose a private place where you can speak freely.

• For best picture and audio quality, a hardwired connection rather than a wireless one should be used if possible. Headphones add additional security.

• Please agree to work with the CLINIC staff and therapists to come up with a safety plan, including identifying emergency contacts in the event of a crisis situation during the sessions.

• Confidentiality should be treated like an in-office session. Please remove outside distractions, turn off cell phones, and close other programs on your computer.

• Understand that the CLINIC may decide to terminate video therapy services if deemed inappropriate to continue therapy through video sessions. In this case, the CLINIC will try to provide in-person care if possible, or refer to another provider or CLINIC, if necessary.

Understand the following limitations of video therapy sessions:

• Any internet-based communication is not 100% guaranteed to be secure and confidential, and agree that the CLINIC is not to be held responsible if any outside party gains access to the video feed.

• In a crisis or emergency situation that needs immediate attention, whereby I am considering seriously harming myself or someone else, I will dial 911, or go to a mental health hospital or emergency room.

Informed Consent Statement:

I have been informed of and understand the risks and procedures involved with using the videoconferencing technology. I agree to the terms listed above and I hereby voluntarily consent to the use of this platform for therapy sessions with my provider. I agree that the CLINIC should not be held liable in the event that any outside party passes technology secu and discovers personal or confidential information. This consent will last for the duration o relationship with this CLINIC. I understand I can withdraw my consent for a video therapy session at any time, and the CLINIC will work with me to find a suitable alternative.

I agree to these terms: Yes _____ No_____

Patient Name: _____ Date of Birth: _____

Parent/Guardian Name (if applicable): _____

Signature of Patient or Parent/Guardian: _____ Date: _____

Signature of Provider: _____ Date: _____

SUWANEE COUNSELING LLC

Consent to Telehealth Services

I, _____, consent to participate in psychotherapy sessions and/ or communication via the Internet, phone, email, or videoconferencing with the professionals and graduate student therapists at the ____ CLINIC.

By choosing to sign this form, I understand that the CLINIC will be using conventional HIPAA-compliant media, and that Telehealth services have been used for many years and with many clients. (In fact, it is approved by federal agencies for mental health services, is supported by research to be effective, and this approach to health care delivery may be right for you.)

I understand that the CLINIC cannot guarantee the privacy or security of any session content or communication being sent through the internet, phone, email, or videoconferencing. It is also possible that there could be disruptions to therapy due to technological difficulties.

Although all text messages, voicemails, and emails are kept confidential, and these communications platforms are encrypted, I understand choosing these methods may lead to information not being protected. I choose to communicate with CLINIC staff and therapists in this manner, understand the risk, and consent to using the following email, cell, and text below:

I consent to using email communication using the following email: _____

I consent to using text messages using the following cell number: _____

I consent to my therapist leaving me confidential voice mail messages on the above cell number: YES ___ NO ___

Signature of Patient or Parent/Guardian: _____ Date: _____

Printed Name of Patient or Parent/Guardian: _____

Signature of Provider: _____ Date: _____

Printed Name of Provider: _____

Adult Signer's Initials: _____