INFORMED CONSENT TO TELEHEALTH at COUNSELING ASSOCIATES OF MA & NH

I understand I have the following rights under this agreement:

I have a right to confidentiality with Telehealth under the same laws that protect the confidentiality of my medical information for in-person psychotherapy. Any information disclosed by me during the course of my therapy, therefore, is generally confidential.

There are, by law, exceptions to confidentiality, including mandatory reporting of child, elder, and dependent adult abuse and any threats of violence I may make toward a reasonably identifiable person. I also understand that if I am in such mental or emotional condition to be a danger to myself or others, my therapist has the right to break confidentiality to prevent the threatened danger. Further, I understand that the dissemination of any personally identifiable images or information from the Telehealth interaction to any entities shall not occur without my written consent.

I understand that while psychotherapeutic treatment of all kinds have been found to be effective in treating a wide range of distressing mental health issues, as well as, personal and relational issues, there is no guarantee that all treatment of all clients will be effective. Thus, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.

I further understand that there are risks unique and specific to Telehealth, including but not limited to, the possibility that therapy sessions or other communication to others regarding my treatment could be disrupted or distorted by technical failures or could be interrupted or could be accessed by unauthorized persons. I understand that Telehealth treatment is different from in-person therapy and if my therapist believes another form of therapeutic services, such as in-person treatment, would better serve me this will be discussed.

I understand and agree to the following information:

I understand that I will need to download an application and/or software to use this platform. I also need to have a broadband Internet connection or smart phone device with a good cellular connection at home or at the location deemed appropriate for services. I understand that in the case of technology failure. I may contact _____a counselor of MA & NH via phone to coordinate alternative methods of treatment. I understand that I am responsible for (a) providing the necessary computer or device, telecommunications equipment and internet access for Teletherapy sessions; (b) the information security on my computer or device, (c) arranging a location with sufficient lighting and privacy that is free from distractions and intrusions, and sufficient for privacy to protect my personal health information. I understand that I am responsible for information security on my computer or device including copies of emails or other communication.

Your psychotherapist at Counseling Associates of MA & NH will be using _____ for video-based sessions. Teletherapy via this chosen telehealth platform are considered to be secure because these platforms are reported by their

manufactures to be encrypted and meeting HIPAA-acceptable privacy guidelines. Despite the manufacturer's representations, the therapist and Counseling Associates of MA & NH does not independently certify that these products meet the encryption criteria for HIPPA compliance, and therefore release this therapist and Counseling Associates of MA & NH from any liability in the event the teletherapy platform is not secure and confidential as reported by the manufacturer.

I am responsible for contacting my insurance company, if applicable in order to determine what my out-of-pockets costs may be. I authorize insurance benefits to be paid directly to my therapist at Counseling Associates of MA & NH. My therapist at Counseling Associates of MA & NH may release any information to my insurance provider required for processing my claims. If insurance does not cover Telehealth, or I use a self-pay option, I agree to pay the fees outlined in the general informed consent.

I understand that I can withdraw my consent to Telehealth communications by providing written notification requesting the change. My signature below indicates that I have read this Agreement and agree to its terms.

I understand that teletherapy is not intended for nor will it be utilized for emergency services. If emergencies arise, I will be required to seek face to face consultation and evaluation, and by signing this consent, I agree in advance to seek such care if I or my therapist Counseling Associates of MA & NH deem this necessary. I understand that imminent safety risks may require my therapist at Counseling Associates of MA & NH to access Emergency Services provided by police, 911 and/or ambulance to ensure my safety. If I am experiencing an emergency situation, I understand that I can call 911, my Primary Care Physician or proceed to the nearest hospital emergency room for help. Additionally, 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.

I have reviewed this ***INFORMED CONSENT to TELEHEALTH*** form and agree to all information; policies and procedures outlined herein, and understand that these will apply to Telehealth services.

I have read and understand the information provided above. I have the rights to discuss any of this information with my therapist and to have any questions I may have regarding my treatment answered to my satisfaction. I hereby consent to engaging in Telehealth with my psychotherapist LICSW/ Counseling Associates of MA & NH as part of my clinical services.

Client Name_____
Client Signature _____ Date _____
Parent/Guardian
Signature (if required) _____ Date _____