



Teletherapy Informed Consent Form

I _____ hereby consent to engage in teletherapy with the providers at Child & Family Guidance Center of Texoma. I understand that “teletherapy” includes clinical consultation, treatment, transfer of medical/psychiatric data, telephone conversations and education using interactive audio, video, or data communications. I understand that teletherapy/coaching and consultation also involves the communication of my medical/psychiatric information, both orally and visually. I understand that I have the following rights with respect to teletherapy:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
2. The laws that protect the confidentiality such as HIPPA of my medical information also apply to teletherapy. As such, I understand that the information disclosed by me during the course of my therapy or consultation is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, these include:
 - a. If you, in writing, require such disclosure;
 - b. If child or elder abuse or neglect is disclosed, your counselor is required to notify the Texas Department of Family and Protective Services.
 - c. If you seriously threaten or act in a way that indicates that you are very likely to harm yourself, your therapist may have to seek hospitalization for you, or call your family members or others who can help protect you. If such a situation does arise, he or she will fully discuss the situation with you before taking action, unless there is a strong reason not to for the purposes of safety.
 - d. If your counselor believes that another person is at risk of serious injury or death.
3. I understand that there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of Child & Family Guidance Center of Texoma that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.
4. In addition, I understand that teletherapy based services and care may not be as complete as face- to-face services. I also understand that if my provider believes I would be better served by another form of therapeutic services (e.g. face-to-face services) my provider will recommend I see him or her in office or I will be referred to a professional who can provide such services in my area.
5. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my provider, my condition may not be improve, and in some cases may even get worse. I understand that I may benefit from teletherapy, but that results cannot be guaranteed or assured.
6. I accept that teletherapy does not provide emergency services. During our first session, my provider and I will discuss an emergency response plan. 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.

7. I understand that I am responsible for
 - a. providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions,
 - b. the information security on my computer, and
 - c. arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session.
8. I understand that I have a right to access my medical/psychiatric information and copies of medical records in accordance with HIPAA privacy rules and applicable state law.
9. In order to participate in the teletherapy program, I agree to keep a credit card on file to be charged at time of service. By signing this consent, I agree to the charges on my credit card based on my insurance rates.

I have read, understand and agree to the information provided above.

Client (or Guardian's) Signature

Date

Client's Printed Name