

TELE-THERAPY CONSENT FORM
(REQUIRED IN THE EVENT TELE-HEALTH IS NECESSARY)

This document is an addendum to the informed consent that you signed during our first face-to-face session and contains important information for you about therapy sessions via phone or video. This addendum is designed to inform you about what you can expect regarding your participation in tele-therapy. By signing this document we enter into an agreement that allows you to attend sessions via phone/video with me.

I, _____, hereby consent to engage in tele-therapy with _____. Tele-therapy is a form of psychological service provided via internet technology or by telephone, which can include consultation, treatment, transfer of medical data, emails, telephone conversations and/or education using interactive audio, video, or data communications. I also understand that tele-therapy can involve the communication of my medical/mental health information, both orally and/or visually. Tele-therapy has the same purpose or intention as psychotherapy or psychological treatment sessions that are conducted in person. However, due to the nature of the technology used, I understand that tele-therapy may be experienced somewhat differently than face-to-face treatment sessions.

Technology used:

When I provide phone/video therapy sessions, I am calling you from a cellular/mobile phone or the internet. You may be speaking to me on a landline or cellular/mobile phone or over the internet. I will be calling you from a private location and will be the only person present during our call. It is best if you are in a private location (for example, a room in your home with the door closed) during our phone sessions where you can speak without being overheard or interrupted by others. However, I cannot guarantee the privacy or confidentiality of conversations held via phone/internet, as phone/video calls can be intercepted either accidentally or intentionally. If we lose our phone connection during our session, I will call you back immediately on all phone numbers I have for you, starting with the number on which we were speaking. If we are unable to reach each other due to technological issues, I will attempt to call you back or reach you via the email address you have provided.

I understand that I have the following rights with respect to tele-therapy:

Client's Rights, Risks, and Responsibilities:

1. I, the client, need to be a resident of Illinois. (This is a legal requirement for clinicians practicing in this state under a IL license.)
2. I, the client, have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
3. The laws that protect the confidentiality of my medical information also apply to tele-therapy. 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, which are described in the general Consent Form I received at the start of my treatment with _____.

4. I understand that there are risks and consequences of participating in tele-therapy, including, but not limited to, the possibility, despite best efforts to ensure high encryption and secure technology on the part of my therapist, 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.

5. There is a risk that services could be disrupted or distorted by unforeseen technical problems.

6. In addition, I understand that tele-therapy based services and care may not be as complete as face-to-face services.

7. I understand that I may benefit from tele-therapy, but that results cannot be guaranteed or assured. 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 therapist, my condition may not improve, and in some cases may even get worse.

8. I accept that tele-therapy does not provide emergency services. 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. Clients who are actively at risk of harm to self or others are not suitable for tele-therapy services. If this is the case or becomes the case in future, my therapist will recommend more appropriate services.

9. I understand that there is a risk of being overheard by anyone near me if I am not in a private room while participating in tele-therapy. I am responsible for (1) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my tele-therapy session. It is the responsibility of the psychological treatment provider to do the same on their end.

10. I understand that dissemination of any personally identifiable images or information from the tele-therapy interaction to researchers or other entities shall not occur without my written consent.

Limitations:

I am providing therapeutic services to you as described in the informed consent that you signed during our first face-to-face session. However, it is important to note that there are limitations to phone therapy that can affect the quality of phone sessions. These limitations include but are not limited to the following:

1. Because the sessions are via phone/video, I may not see you, your body language, or your non-verbal reactions to the issues we are discussing.
2. Sometimes I may not hear all of what you are saying (due to cellular phone limitations) and may need to ask you to repeat things.

To reduce the effect of these limitations, sometimes I may ask you to describe how you are feeling, thinking, and/or acting in more detail than I would during a face-to-face session. You may also feel that you need to describe your feelings, thoughts, and/or actions in more detail that you would during a face-to-face session.

Payment:

Payment information will be collected at the time of the first phone /video therapy session. This information will be verbally provided by the client and it is understood it will then be transferred to a HIPPA compliant service, TherapyNotes. Below is authorization for this information to be saved and used for future sessions.

I, _____, authorize _____
to charge my credit card above for agreed upon payment. I understand that my information
will be saved to file for future transactions on my account.

I have read, understand and agree to the information provided above regarding tele-therapy:

Client's Signature: _____ Date _____

Therapist's Signature: _____ Date _____