Protzel Therapy - Telehealth Informed Consent Form

I _____(name of client) hereby consent to engage in telehealth with _____(name of psychotherapist) as part of my treatment process. I understand that "telehealth" includes the practice of education, goal setting, accountability, referral to resources, problem solving, skills training, and help with decision making. Telehealth psychotherapy may include psychological health care delivery, diagnosis, consultation, and psychotherapeutic treatment. Telehealth psychotherapy will occur primarily through interactive audio, video, telephone, email, instant messaging, and/or other data communications.

I understand that I have the following rights with respect to telehealth:

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

(2) The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my sessions is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent.

(3) I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the psychotherapist, that: the transmission of my personal information could be disrupted or distorted by technical failures; the transmission of my personal information could be interrupted by unauthorized persons; and/or the electronic storage of my personal information could be accessed by unauthorized persons.

In addition, I understand that telehealth based services and care may not be as complete as face-to-face services. I also understand that if my psychotherapist believes I would be

better served by another form of intervention (e.g. face-to-face services) I will be referred to a mental health professional who can provide such services in my area. 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 psychotherapist, my condition may not improve, and in some cases may even get worse.

(4) I understand that I may benefit from telehealth psychotherapy, but that results cannot be guaranteed or assured. I understand that the use of any electronic communications are not 100% secure and may have occasional issues with wifi connectivity. All attempts to keep information confidential will be made, but a guarantee of 100% confidentiality cannot be made with inherent issues with electronic/internet based communication systems. Signing this form show an awareness of these issues and a decision by this client to use these systems for video conferencing with Protzel Therapy. I will not hold this therapist liable for any gathering or use of client information that may occur through a potential breach of electronic systems security. All Protzel Therapy communications will utilize encrypted and secure platforms. For videoconferencing, HIPAA compliant 128 bit SSL encrypted platform **wecounsel.com** will be utilized. For text and phone call communications, HIPAA compliant secure (encrypted SIP) VOIP app **phone.com** will be utilized. All email communications are encrypted (end to end) with **paubox.com** services. Paubox's services are HIPAA compliant and are 256 Bit AES encrypted. No extra steps are necessary to receive/send emails to Protzel Therapy. Attachments sent/received are also encrypted/secure through Paubox.

(5) I understand that I have a right to access my personal information and copies of case records in accordance with state law. I have read and understand the information provided above. I have discussed it with my psychotherapist, and all of my questions have been answered to my satisfaction.

(6) By signing this document I agree that certain situations including emergencies and crises are inappropriate for audio/video/computer based psychotherapy services. If I am in crisis or in an emergency I should immediately call 9-1-1 or seek help from a hospital or crisis oriented health care facility in my immediate area. By signing this document I understand that emergency situations include if I have thought about hurting or killing either another person or myself, if I have hallucinations (see or hear things others don't, if I have delusions=beliefs others may consider unrealistic), if I am in a life threatening

or emergency situation of any kind, having uncontrollable emotional reactions, or if I am dysfunctional due to abusing alcohol or drugs. By signing this document, I acknowledge I have been told that if I feel suicidal, I am to call 9-1-1 or the National Suicide Hotline Toll-Free Number at 1-800-784-2433 or other local suicide hotlines.

_____

Signature of client/parent/guardian Date

_____

Printed name of client/parent/guardian (*as clearly as possible*)

_____

If signed by other than client indicate relationship

_____

Signature of telehealth psychotherapist Date