ART OF THE HEART
COUNSELING SERVICES LLC

## TELEHEALTH (VIDEO/PHONE) INFORMATION AND COUNSELING AGREEMENT

Client Name: _____ Date of Birth: _____

The purpose of this form is to obtain your consent to participate in telehealth, which involves counseling by phone or secure video.

**Benefits include:**

1. It's more convenient. It can decrease the time commitment of therapy since there is no travel time.
2. You can be seen even if you are unable to travel to the office for various reasons.
3. You can be seen when you travel within the state, or even when you move within the state.
4. You can always choose to schedule a face-to-face session, when desired.

**Limitations/Risks include:**

1. There is a greater chance of misunderstanding -- due to technology limits, there might be some loss in the nonverbal communication between the therapist and you.
2. The therapist does not have any control of interruptions in your setting.
3. Internet connections could cease working or become too unstable to use.
4. The telehealth platform or our computers/smartphones can have sudden failure or run out of power.
5. You may feel more emotional distance related to the lack of in-person contact and presence.
6. Privacy/confidentiality of conversations held via phone cannot be guaranteed, as these can be intercepted accidentally or intentionally. We cannot guarantee that third-parties will not access video calls.
7. The therapist cannot immediately intervene in-person if you are in crisis.

**Is it right for you?**

Telehealth is not a good fit for everyone, so prior to starting telehealth, we will discuss whether it is appropriate for you. If at any point you find the telehealth platform difficult to use or distracting you from our work, please let me know. You have the right to discontinue receiving telehealth counseling at any time, without consequence. You have a choice of moving to phone or in-person sessions. Likewise, if telehealth is not effective for your treatment, we may discontinue this treatment option.

**Logistics**

1. If we are connecting by video, you will have a link to sign in to our secure and HIPAA-compatible video platform. You don't need to set up an account of any kind in advance. It is OK to "arrive" early. If we are connecting by phone, you will receive a call at the scheduled time.
2. The therapist will be in a private location. You also need to be in a private location where you can speak openly without being overheard or interrupted by others to protect your own confidentiality. If you choose to be in a place where others can hear you, we cannot be responsible for your confidentiality.
3. At the start of the session, the therapist may verify your location (street address). This enables us to send help, if needed, and to verify that you are in-state. The therapist can only provide therapy to you while you are in the state where the therapist is licensed.
4. Do not invite others to join for any part of the session without prior discussion.
5. Please be sure to have a cell phone with you or be near a phone, in case video gets cut off.

**You may have a better experience if you:**

1. Use a computer or tablet instead of a cell phone so that you can see me better.
2. Make sure your device is fully charged.



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3. Wear a two-ear headset with microphone (this can help us hear each other)
4. Close other applications or programs on your computer.
5. Make sure you have strong internet connection.
6. Consider how you will reduce interruptions (ex. talking to family in advance about your need for privacy during that hour, using a "do not disturb" sign on your door, etc.)
7. Find a location where your face will be well-lit so your therapist can see your facial expressions clearly.

**Security**

- AHCS uses video software and hardware tools that adhere to security best practices and legal standards for the purposes of protecting your privacy.
- It is not recommended that you communicate using a public wireless network.
- You have the sole responsibility for security and privacy of your devices, equipment, and internet connection.

**Recording of Sessions:**

- No sessions will be recorded by AHCS without your written permission. Please note that recording or screenshots of any kind of any session are not permitted and are grounds for termination of the client-therapist relationship.

**Payment for Services:**

Payments for services must be made prior to our session or the day of the session. Your credit card on file will be charged on the session date. If you prefer not to use a credit card, you may pay for sessions ahead of time by check or through an electronic cash transfer service. If you have insurance and we are in their network, AHCS will bill insurance on your behalf, but you remain responsible for any portion they do not pay.

**Session Cancellations:**

Phone/video sessions are treated as in-office sessions when it comes to late cancellations and no-shows -- 24-hour advance notice is required, otherwise you will be charged the cancellation fee except for cases of unforeseen medical emergency. Cancellations should be communicated via email and phone.

**Emergencies and Confidentiality:**

Since you will be at a distance, please list an emergency contact for you:

_____

Full Name Relationship Phone Number(s)

If you are in crisis and the session is disconnected, you agree to call 911 or 211, go to your local emergency room immediately or contact the National Suicide Hotline at 800-784-2433 if you cannot reach your therapist.

Please share with your therapist if you have severe feelings of helplessness, hopelessness, or wanting to hurt yourself or others. There are many steps we can take to help, even at a distance. However, if your therapist has extreme concerns about your safety at any time during a telehealth session, you may need come to the office, or your therapist may need to call your support system or emergency services to keep you safe.

Please note that everything in our informed consent that you signed, including all the confidentiality exceptions, still applies during phone/video sessions.



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**Consent to Participate in Telehealth Sessions**

I, _____, have either opted to or have been asked to receive behavioral health services via telemedicine. I understand that I will be receiving health care or evaluation services through interactive videoconferencing equipment. I understand that, at this time, there are no known risks involved with receiving my care in this way.

My health care provider explained to me how the video conferencing technology that will be used to affect such a consultation will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my provider. I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.

I understand that my participation in telemedicine is voluntary, and I may decide to stop using telemedicine at any time, verbally or in writing. I understand that my decision to stop participation in telemedicine will be documented in my medical record. I understand that I have the option to transfer to in-office services should I choose to, or should it be decided that this is the most effective setting for my treatment needs.

I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

**CONSENT TO USE THE TELEHEALTH BY SIMPLEPRACTICE SERVICE**

Telehealth by SimplePractice is the technology service we will use to conduct telehealth videoconferencing appointments. It is simple to use and there are no passwords required to log in. By signing this document, I acknowledge:

1. Telehealth by SimplePractice is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
2. Though my provider and I may be in direct, virtual contact through the Telehealth Service, neither SimplePractice nor the Telehealth Service provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.



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3. The Telehealth by SimplePractice Service facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.
4. I do not assume that my provider has access to any or all of the technical information in the Telehealth by SimplePractice Service – or that such information is current, accurate or up-to-date. I will not rely on my health care provider to have any of this information in the Telehealth by SimplePractice Service.
5. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.
- That I understand this document will become a part of my medical record.
- That I am giving Art of the Heart Counseling Services LLC permission to communicate with your emergency contact if there is any concern about your safety.

Signature: _____ Printed Name: _____ Date: _____



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