Informed Consent for Participation in eTherapy (Telehealth)

This document supplements the "Informed Consent" and "Practice Policy" documents.

Client/ Parent or managing conservator's Full Name _____

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Phone: _____ E-mail: _____

Types of Service Provided: I offer in-person, phone, and online (video) therapy. We will discuss in your first session if your goals are more suitable for in-person therapy or can be addressed through phone or online therapy. It is okay if at any point in therapy you would like to switch format (e.g., from phone to online). If you or I believe that you would be better served by another specialist or by a format I cannot provide, I will provide you an appropriate referral.

What You Can Expect from eTherapy: Similar to in-person therapy, the duration of phone or online therapy is different for each person. We can discuss any concerns you have about this at any time. If you are not feeling satisfied with the therapeutic experience for any reason, please discuss this directly with me. I will work with you to uncover what might be preventing progress, modify goals with you if appropriate, and make a referral to other professionals if necessary.

Please understand that services over the phone and internet have limitations compared to in-person sessions, including the lack of "personal" face-to-face interactions, and the lack of visual and audio cues. This can sometimes result in misunderstandings or miscommunication. If this occurs, please address it with me, as transparency and trust are vital to good therapy. If due to internet issues we lose connection during online therapy and are unable to reconnect within 5 minutes, I will call you. If we cannot reestablish contact within 10 minutes, session will be canceled and we will reschedule.

Emergency Protocols: To be able to respond to emergencies that arise during therapy, I need to know your location at the beginning of each session. I also need a contact person whom I may contact on your behalf in a life-threatening emergency situation. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency. If this person cannot be reached, you understand that I may need to contact appropriate authorities.

Your home address: _____

EMERGENCY CONTACT NAME **TELEPHONE NUMBER**

(1) _____

(2) _____

(3) _____

By signing this document, you understand that phone or online therapy is not a substitute for medication under the care of a psychiatrist or doctor. You also understand that phone or online therapy, similar to in-person therapy, is not a 24-hour service. If you experience a crisis after-hours, you agree to contact a crisis hotline, call 911, or go to a hospital emergency room.

Mecklenburg County crisis hotline: (704) 566-3410

eTherapy Confidentiality: When we engage in phone or online therapy, please note that confidentiality is a shared responsibility. I will protect what you share with me by using a password-protected network, as well as use a HIPAA-compliant online therapy system provided by Spruce. You are responsible for creating as much privacy as possible when engaging in phone or online therapy. Strategies for doing so include:

- Using a private room
- Wearing headphones (equipped with a microphone)
- Communicating with those sharing your residence the need for privacy
- Limiting who has access to your computer
- Fully exiting all online sessions

By signing this document, you agree to using the Spruce system on your computer or cell phone (do not worry, I will assist you in setting it up). You also agree that there will be no recording of any of the sessions. All information disclosed within sessions and written records pertaining to those sessions are confidential and cannot be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law. Federal privacy laws that protect the confidentiality of your health information also apply to telehealth.

Confidentiality of E-mail and Text: My e-mail is not encrypted. Therefore, if you choose to e-mail me, please limit the contents to basic issues such as cancellation or change in contact information. I will not respond to personal and clinical concerns via e-mail. If you need to reach me via text, you can protect the confidentiality of your text by texting me through the Spruce app on your phone. Regular texts sent to my phone number will not be encrypted.

Please note that although we will work together to protect your personal information from unauthorized disclosure over electronic communication, there is the possibility that viruses or other malicious software may obtain your private information on your computer system and release and/or use your information without your knowledge. There may be other risks associated with internet communication which are unknown at this time. Therefore, you agree to release me from all liability and responsibility during the process of therapy.

Payment for Services: Payments for services must be made prior to, or at, the time of each session. Payments are accepted in the form of credit card, check, or cash. Please discuss with me if you have any concerns about this.

Cancellation policy: You will be billed for the session if you miss an appointment without providing at least 24-hour notice.

By signing this Informed Consent for Participation in eTherapy, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein and in the Informed Consent and Practice Policy documents. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

_____ _____
Client/parent or managing conservator Signature Date

_____ _____
Client/parent or managing conservator Signature Date

_____ _____
Therapist Signature Date

Please **do not** e-mail this document.

This document can be returned to me in-person or sent through fax: (704) 519-2582