Telehealth Therapy Informed Consent

I, _____, hereby consent to engaging in telehealth therapy with Kate Casey LPC, JD of Autumn Ridge Counseling and Wellness as part of my psychotherapy treatment. I understand this Consent Form is an Addendum to the Consent Form for face to face therapy. I understand that telehealth therapy includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, data communications or telephone.

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

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment or risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
(2) The laws and regulations that protect the confidentiality of my medical information, HIPAA, also apply to telehealth therapy. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, disabled, 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.
(3) I understand that there are risks and consequences of telehealth therapy, including, but not limited to, the possibility, despite reasonable efforts on the part of Kate Casey LPC,JD that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons. In addition, I understand that telemedicine 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 psychological services (e.g. face-to-face services) I will be referred to a practitioner who can provide such services in my area.
(4) I understand that I may benefit from telehealth therapy, but that results cannot be guaranteed or assured.
(5) I understand that I have a right to access my medical information and copies of medical records in accordance with Texas State law.
(6) I understand that telehealth therapy sessions will be conducted through the HIPAA approved platform, Doxy.me.
(7) I understand that utilizing video conferencing as a communication medium may be subject to technical difficulties, therefore possibly impacting my therapeutic experience. I understand that I am responsible for the efficiency of my technological equipment. I understand that if my equipment is not functioning properly that it may interfere with the telehealth therapy services.

I have read and understand the information provided above. I have discussed it with Kate Casey LPC, JD and all of my questions have been answered to my satisfaction.

_____ _____

Signature/Signature of Parent if Client is a Minor Date