Feathergill and Associates, LLC
Consent for Telehealth Services

Client Name: _____ DOB _____

Telehealth Informed Consent Form

I _____, consent to engaging in telehealth with Feathergill and Associates, LLC as a part of the therapy process and my treatment goals. I understand that telehealth psychotherapy may include mental health evaluation, assessment, consultation, treatment planning, and therapy. Telehealth will occur primarily through interactive audio/video, or telephone meetings. Many insurance companies cover telehealth services. I have been advised that it is my responsibility to check my benefits, and I understand that a quote of benefits by an insurance company is not a guarantee of payment. I have been informed that I am responsible for any services not covered by insurance, or any co-pays or coinsurance due.

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

1) I have the right to withhold or remove consent at any time without affecting my right to future care or treatment, nor endangering the loss or withdrawal of any program benefits to which I would otherwise be eligible.

2) The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information released by me during the course of my sessions is generally confidential. There are both mandatory and permissive exceptions to confidentiality including but not limited to reporting child and vulnerable adult abuse, expressed imminent harm to oneself or others, or as a part of legal proceedings where information is requested by a court of law. 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 Feathergill and Associates, LLC that: the transmission of my personal information could be disrupted or distorted by technical failures and/or the transmission of my personal information could be interrupted by unauthorized persons. I further understand that Feathergill and Associates will utilize only HIPAA approved platforms for telehealth services, and that I am responsible for accessing such services.

   I understand that I may benefit from telehealth services, but that results cannot be guaranteed or assured. In addition, I understand that telehealth based services and care may not be as complete and in-person services. I understand that if my therapist believes I would be bettered served by other interventions, my therapist will recommend that I seek such services in my area. My therapist has agreed that they will

do their best to assist me in finding a referral to a mental health professional who can provide such services. I also understand that there are potential risks and benefits associated with any form of mental health treatment, and that despite my efforts and efforts of my therapist, my condition may not improve, or may have the potential to get worse.

4) I understand that all attempts to keep information confidential while using these systems will be made by Feathergill and Associates, but a guarantee of 100% confidentiality cannot be made due to a lack of control over the platforms and servers of the Service Providers. Signing this form shows an awareness of these issues and a decision by this client to use these systems for telehealth services. I will not hold Feathergill and Associates, LLC or its staff liable for gathering or use of client information by these service providers.

5) I understand I have the right to access my personal information and copies of case notes. I have read and understand the information provided above. I have discussed these points with my therapist, and all of my questions regarding the above matters have been answered to my approval.

6) I understand that some States limit the access to counseling and psychotherapy to clinicians who are licensed in that state. This may mean a limited number of sessions in a calendar year for out of state clinicians. Your therapist will determine the number of sessions allowed and provide you with this information.

7) 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 911 or go to the nearest hospital or crisis facility. By signing this document I understand that emergency situation may include thoughts about hurting or harming myself or others, having uncontrolled psychotic symptoms, if I am in a life threating or emergency situation, and/or if I am abusing drugs or alcohol and are not safe. By signing this document, I acknowledge I have been told that if I feel suicidal I am to call 911, local county crisis agencies or the National Suicide Hotline at 1-800-784-2433.

Signature of client/parent/guardian Date

Printed name of client/parent/guardian Relationship (If applicable)

Signature of therapist/person informing of rights Date