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Telehealth Consent

I, ____, hereby consent to participate in telemental healthcare (telehealth) with Debbie Butler, LMFT, as part of my psychotherapy. I understand that telehealth is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations. This can include both video and audio forms of communication, via the internet or telephone. Telehealth services do not include texting or e-mail. Agreements for telehealth are governed by all the same ethics and laws that cover in-office, in-person, face-to-face psychological services. So, all other policies and consents in the psychotherapist's office agreement forms apply to telehealth services. This document is an addendum to and does not substitute for our standard in-office services agreements.

I understand the following with respect to telehealth health:

1) I understand that I have the right to withdraw consent to participate in telehealth services at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled. It is also my responsibility to discuss prior to the telehealth session which medium will be used, how to use it, and any necessary login codes.
2) I understand that there are risks, benefits, and consequences associated with telehealth health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies. I understand I am responsible for information security on my computer, laptop, tablet, or smartphone. I understand that Debbie Butler uses a software program, Zoom, that is HIPAA compliant regarding confidentiality requirements to maximize my confidentiality. The environment I use should be free from unexpected or unauthorized intrusions or disruptions to our communication. There is a risk of being overheard by a third party near me if I do not conduct the session in an enclosed private room, with reasonable sound barriers, and with no one else present or observing.
3) I understand that there will be no recording of any of the online sessions by either party without the express permission by both parties. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.
4) I understand that during a telehealth health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at 206-669-1513 to discuss since we may have to re-schedule.

5) I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telehealth health unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).

6) I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telehealth health services are not appropriate and a higher level of care is required.

7) I understand that Debbie Butler may need to contact my emergency contact and/or appropriate authorities in case of an emergency. In case of an emergency, my usual location is: ____ and my emergency contact person's name, address, phone: _______________________________

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I have read the information provided above and discussed it with Debbie Butler. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

Signature of Patient: _________________________ Date ________________________

Signature of Patient: _________________________ Date _________________________

Debbie Butler, M.S., LMFT