

Limitless Counseling Services (LCS) LLC
2670 N. Columbus Street Suite G Lancaster, Ohio 43130
Phone: (740) 901-1231 Fax: (740) 901-3021

**Teletherapy/Telehealth Informed Consent Form
In Response to the COVID-19 Nationwide Public Health Emergency**

I, _____, hereby consent to engaging in teletherapy with Limitless Counseling Services LLC. I understand that “teletherapy” includes the practice of mental health and/or substance abuse care, delivery, diagnosis, consultation, treatment and education using interactive audio, video, or data communications of my medical/mental health information, both orally and visually. Limitless Counseling Services LLC is able to provide teletherapy service via Zoom and/or My Clients Plus and Jituzu software (HIPPA compliant video platform services). If there are additional methods that I prefer to conduct services, I will discuss this with my therapist to determine the best course of action.

I understand that I have the following rights with respect to teletherapy:

- (1) I have the right to withhold or withdraw consent at any time without affecting my right to future care of treatment nor risking the loss or withdrawal of any therapy benefits to which I would otherwise be entitled.
- (2) The laws that protect the confidentiality of my medical information also apply to teletherapy. 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, elder, and dependent adult abuse; expressed threats of violence toward 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 from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, 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 (e.g. hacking); and/or the electronic storage of my medical information could be accessed by unauthorized persons. In addition, I understand that teletherapy based services and care may not be as complete as face-to-face services. I also understand that there are potential risks and benefits associated with any form of psychotherapy.
- (4) I understand that I may benefit from teletherapy, 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 Ohio law.
- (6) I understand that, per the ethical guidelines of the State of Ohio, teletherapy services can only be provided to those residing in the state of Ohio at the time of service*

** Due to COVID-19 nationwide public health emergency the rules governing this restriction have been suspended and therapists at Limitless Counseling Services LLC are able to provide teletherapy to most out of state residents. It is my responsibility to check my state's licensure requirements for telehealth.*

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(7) I understand that teletherapy is not always a covered service by my insurance plan, and it is my responsibility to check with my individual plan to determine if teletherapy is authorized for Out-of-Network coverage/benefits. Ultimately, I understand that I am responsible for all fees related to teletherapy that insurance does not cover.

(8) Teletherapy will be billed at the same rate of individual services.

(9) Teletherapy is a temporary service that is being offered to all clients of Limitless Counseling Services LLC due to extreme circumstances as a precautionary measure. Once these circumstances abate, therapy sessions will return to in-person services. Please contact your therapist directly if you have any questions.

(10) I have provided Limitless Counseling Services LLC with the following information and I have given my permission to utilize my email address as a method to contact me.

- a) My home address
- b) My phone number
- c) My email address
- d) A secondary emergency contact (name/phone #)

I have read and understood the information provided above. I have discussed any questions I have with my provider, and all of my questions have been answered to my satisfaction.

Client Signature _____ Date _____

Tips for sessions through video chat:

- *Ensure that your location is private and secure. Try to conduct your session in a room that allows you to separate yourself from distractions and any non-participants in the home who might overhear. Make arrangements for childcare if necessary.*
- *Make sure there is sufficient lighting. Dark and solid colored clothing works best and lowers risk of interference with video image. Avoid large pieces of jewelry that reflect light. Take off hats and sunglasses that limit the view of your face.*
- *Only use a Wi-Fi network that is secure via password protection, no public Wi-Fi when/if possible.*
- *Position yourself and camera so that you are visible from at least the waist up. If there are multiple participants, make sure everyone is in view.*