Empowerment Oasis

TELEMENTAL HEALTH COUNSELING POLICY

I _____ hereby consent to engage in teletherapy services with Wanda Kellyman, NCC, LCMHC, as part of my ongoing therapy treatment.

I understand that teletherapy is a mode of delivering health care services, including psychotherapy, via communication technologies (e.g., internet, email, or phone) to facilitate diagnosis, consultation, treatment, education, and the transferring of protected health information both orally and/or visually.

By signing this form, I understand and agree to the following:

1. I have a right to confidentiality regarding my treatment and related communications via Telehealth under the same laws that protect the confidentiality of my treatment information during in-person psychotherapy. The same mandatory and permissive exceptions to confidentiality outlined in the Professional Disclosure Statement I received from my counselor, Wanda Kellyman, NCC, LCMHC, also apply to my Telehealth services.
2. I understand that my counselor must verify my full name and current location at the beginning of each Telehealth session.
3. I understand that teletherapy services and care may have limitations as compared to in-office sessions and that if Wanda Kellyman, NCC, LCMHC, feels that I would be better served by another form of therapy such as in-office sessions that Wanda Kellyman, NCC, LCMHC will make this recommendation and/or referral.
4. I understand that while Telehealth effectively treats a wide range of mental and emotional issues, there is no guarantee that Telehealth is effective for all individuals. Therefore, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.
5. Wanda Kellyman, NCC, LCMHC, will utilize all reasonable efforts and compliant video sources to protect your information. Still, it is your responsibility to create an environment in your setting to ensure the confidentiality and integrity of your health information within your environment to the best of your ability.
6. I understand that there is a risk of being heard by people near me and that I am responsible for using a location that is private and free from distractions or intrusions.
7. I understand that I have the right to withhold or withdraw consent at any time for teletherapy without affecting my right to future care or treatment or risking the loss or withdrawal from in-office sessions.
8. I understand that the laws and regulations are in place to protect the confidentiality of your medical information also apply to teletherapy, which will also include but is not limited to the same limitations to client privacy, such as mandated reporting of child abuse and neglect, a threat to self or others, etc.
9. I understand that there are risks and consequences from teletherapy, including, but not limited to, the possibility that despite reasonable efforts on the part of Wanda Kellyman, NCC, and LCMHC that the transmission of information could be disrupted or distorted by technical failures,

interrupted by unauthorized persons, and or the electronic storage of my information could be accessed by unauthorized persons.

10. I understand my counselor will make reasonable efforts to ascertain and provide me with emergency resources in my geographic area. I further understand that my counselor may be unable to assist me in an emergency. If I require emergency care, I understand that I may call 911 or proceed to the nearest hospital emergency room for immediate assistance.

I have read and understand the information provided above, have discussed it with my counselor, and understand that I have the right to have all my questions regarding this information answered to my satisfaction. Your signature on this page indicates that you understand and accept these conditions for treatment.

I appreciate your cooperation!

Client/Parent/Guardian: _____ Date: _____

Witness: _____ Date: _____