Empowerment Oasis

TELEMENTAL HEALTH COUNSELING POLICY

I _____________________________ hereby consent to engage in teletherapy services with Wanda Kellyman, NCC, LCMHCA 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, LCMHCA, also apply to my Telehealth services.
2. I understand that at the beginning of each Telehealth session my counselor is required to verify my full name and current location.
3. I understand that teletherapy services and care may have limitations as compared to in office sessions and that if Wanda Kellyman, NCC, LCMHCA feels that I would be better served by another form of therapy such as in office sessions that Wanda Kellyman, NCC, LCMHCA will make this recommendation and/or referral.
4. I understand that while Telehealth has been found to be effective in treating 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, LCMHCA will utilize all reasonable efforts and compliant video sources to protect your information, but it is your responsibility to create an environment in your setting to ensure to the best of your ability to protect your confidentiality and integrity of your health information within your environment.
6. I understand that there is a risk of being overheard by persons 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 applies to teletherapy, which will also include but are not limited to the same limitations to client privacy such mandated reporting of child abuse and neglect, 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, LCMHCA 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 that 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 not be able 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.

Thank you for your cooperation!

Client/Parent/Guardian: ___________________________________ Date: ______________

Witness: ____ Date: ______________