

ABC Center
3939 Gentilly Blvd., New Orleans, LA 701xx
Jane Doe, Ph. D.
LPC # ____; LMFT # ____; NCC # ____
504-329-xxxx

**Teletherapy Declaration and Informed Consent (An Additional Document to the normal Declaration of Practices used for In-Person Sessions)
TO CLIENTS**

Licensed mental health professionals are required by their licensing boards to provide you, the client, with certain basic information. You have already received and signed the basic Declaration of Practices and Procedures from Dr. Jane Doe. This Teletherapy Policy & Procedure document describes certain important aspects of therapy unique to Teletherapy. I am providing you this information for your review and agreement. Please read it carefully and discuss any questions you have before signing below.

By signing this form, you are not making a commitment to continue teletherapy therapy as a permanent modality, but you will continue to have that option should you and Dr. Doe both agree that it is in your best interest.

QUALIFICATIONS OF CLINICIAN

I have completed XX hours of live telehealth care training in addition to my professional qualifications as a clinician. This training covered the Law and Ethics and Clinical Skills specifically related to telehealth care. I will continue to receive at least three hours of continuing education in the area of telemental health every two years. All teletherapy sessions will be conducted through Doxy.me which is encrypted to the federal standard.

Scheduling and Structure of Teletherapy

Counseling sessions will be scheduled in 50 minute increments, unless you and Dr. Doe agree on a different time schedule. The next session will be scheduled at the end of the current session, unless otherwise agreed upon. The structure of sessions will be dependent on the treatment plan and interventions being used.

Ethical and Legal Rights Related to Teletherapy

Dr. Doe will not be conducting Teletherapy in any other state than Louisiana unless she specifically seeks and obtains licensure in the other state. It is important for you, as a client, to realize if you should relocate to another state, Dr. Doe's ability to continue to conduct teletherapy

would be dependent on her decision whether or not to seek licensure in the state to which you are relocated.

RESPONSIBILITIES OF THE CLIENT

All clients should:

- Be appropriately dressed during sessions.
- Avoid using alcohol, drugs, or other mind-altering substances prior to session.
- Be located in a safe and private area appropriate for a teletherapy sessions.
- Make every attempt to be in a location with stable internet capability.

Clients should NOT:

- Record sessions unless first obtaining Dr. Doe's permission.
- Have anyone else in the room unless you first discuss it with Dr. Doe.
- Conduct other activities while in session (such as texting, driving, etc.).

* If the client is a minor, a parent or guardian must be present at the location/building of the teletherapy session (unless otherwise agreed upon with the therapist).

POTENTIAL COUNSELING RISKS

When using technology to communicate on any level, there are some important risk factors of which to be aware. It is possible that information might be intercepted, forwarded, stored, sent out, or even changed from its original state. It is also possible that the security of the device used may be compromised. Best practice efforts are made to protect the security and overall privacy of all electronic communications with you. However, complete security of this information is not possible. Using methods of electronic communication with us outside of our recommendations creates a reasonable possibility that a third party may be able to intercept that communication. It is your responsibility to review the privacy sections and agreement forms of any application and technology you use. Please remember that depending on the device being used, others within your circle (i.e. family, friends, employers, & co-workers) and those not in your circle (i.e. criminals, scam artists) may have access to your device. Reviewing the privacy sections for your devices is essential. Please contact me with any questions that you may have on privacy measures.

POTENTIAL LIMITATIONS OF TELETHERAPY

Teletherapy is an alternate form of counseling and should not be viewed as a substitution for taking medication that has previously been prescribed by a medical doctor.

It has possible benefits and limitations. By signing this document, you agree that you understand that:

- Teletherapy may not be appropriate if you are having a crisis, acute psychosis, or suicidal/homicidal thoughts.
- Misunderstandings may occur due to a lack of visual and/or audio cues.
- Disruptions in the service and quality of the technology used may occur.

- While I do not file insurance claims, I can make an invoice available to you to file with your insurance company. Please check with them ahead of time to be sure your policy covers telemental health counseling.

EMERGENCY SITUATIONS

The following items are important and necessary for your safety. The clinician will need this information in order to get you help in the case of an emergency. By signing this consent to treatment form you are acknowledging that you have read, understand, and agree to the following:

- The client will inform Dr. Doe of the physical location where he/she is, and will utilize consistently while participating in sessions and will inform Dr. Doe if this location changes.
- In the first teletherapy session, you will provide the name of a person Dr. Doe is allowed to contact in the case she believes you are at risk. You will be asked to sign a release of information for this contact.
- In the first teletherapy session, you will provide information about the make, model, color, and tag number of your automobile.
- In each session the you will provide information about the nearest emergency room or emergency services (such as fire station, police station, if there is not an emergency room nearby.)
- Depending on the assessment of risk and in the event of an emergency, you or Dr. Doe may be required to verify that the emergency contact person is able and willing to go to the client's location and, if that person deems necessary, call 911 and/or transport the client to a hospital. In addition to this, Dr. Doe may assess, and therefore require that you, the client create a safe environment at your location during the entire time of treatment. If an assessment is made for the need of a "safe environment" a plan for this safe environment will be developed at the time of need and made clear by Dr. Doe.
- In the case of a need to speak to me between sessions, please call, or text, and leave a message. I do not provide emergency services on a 24-hour basis. If your emergency is after hours, please contact your nearest emergency room. Typically contact between sessions is limited to arranging for appointments.
- If you are in need of the services of other professionals, I am happy to consult and coordinate with them. Clients should not routinely be meeting with more than one counselor, unless the two counselors have agreed to coordinate your care.

BACKUP PLAN IN CASE OF TECHNOLOGY FAILURE

A phone is the most reliable backup option in case of technological failure. It is, therefore, highly recommended that you always have a phone at your disposal and that I know your phone number. If disconnection from a video conference occurs, end the session and I will attempt to restart the session. If reconnection does not occur within five minutes, call me at the contact number I have provided. If, within 5 minutes, I do not hear from you, you agree (unless otherwise requested) that I can call the provided phone number.

CONSENT TO TELETHERAPY TREATMENT

I have read this Declaration of Telehealth Policies and Procedures and my signature below indicates my full informed consent to services provided by Dr. Jane Doe via teletherapy treatment.

Client Signature: _____ Date: _____

Client Signature: _____ Date: _____

Clinician's Signature: _____ Date: _____

Parental Authorization for Minors I, _____, give permission for _____ (clinician's name) to conduct counseling with my (relationship), _____, (name of minor) _____.

(Options for recording your signature:

- You may sign this document while I am watching via video; or
- You may scan the signature page and send it via text to me; or
- You may snap a picture and send it via text to me;
- You may mail your signed document, sending it to me at the address at the top of this document.)