Telehealth Informed Consent

The telehealth platform allows access to mental health services that might not otherwise be available to me due to my mental health, and/or my physical, resource, or geographic limitations.

Technology: I will need to have a broadband internet connection or a smart phone device with a good cellular connection at home or at the location deemed appropriate for services. Doxy.me is the chosen platform for online therapy sessions at Counseling Solutions. Doxy.me is a free, HIPAA compliant platform which means your session is safe and secure. I may visit doxy.me/patients for more information. I also understand that in case of technology failure, I may contact Counseling Solutions via phone to coordinate alternative methods of treatment.

Financial Obligations: I agree to have my credit/debit card information on file with Counseling Solutions. I understand my card will be billed no sooner than 48 hours from the day of my appointment. I understand fees may be associated with my telehealth services for cancellations, no shows, and insufficient funds. If my card is declined, Counseling Solutions will cancel my appointment and I will be charged in accordance with the cancelation policy. (*See chart for fees)*

Clients Using Insurance: I am responsible for contacting my insurance company, if applicable, to determine what my out-of-pocket costs may be. I authorize insurance benefits to be paid directly to Counseling Solutions and that Counseling Solutions may release any information to my insurance provider required for processing my claims. (*See chart for fees)*

Self-Pay Clients: I am aware of the fees associated with telehealth appointments and agree to pay at the time of my appointment. I understand that I am responsible for cancelled telehealth appointments in accordance with the Counseling Solutions cancellation policy as documented by my signature on the Informed Consent. (*See chart for fees)*

Telehealth Fees:

Individual Therapy with a Licensed Therapist (Non-Intern)	$45 for 30 Minute Session (Self-Pay) $70 for 60 Minute Session (Self-Pay) **(Clients using insurance are responsible for the out-of- pocket costs as outlined by the insurance company.)**
Marital/Couples Therapy with Licensed Therapist (Non-Intern)	$60 for 30 Minute Session $85 for 30 Minute Session **(Clients using insurance are responsible for the out-of- pocket costs as outlined by the insurance company.)**
Individual Therapy with a Licensed Intern	$30 per 45 Minute Session (Self-Pay)
Cancellation/No Show Fees	With Licensed Therapist (Non-Intern) $40 With Licensed Intern $20
Insufficient Funds Fees	$35 per Transaction

Scheduling: I understand that scheduling is conducted through Counseling Solutions and is based on my therapist's availability. Telehealth appointments are considered outpatient services and not intended as a substitute for emergency or crisis services. Crisis or mental health emergencies should be directed to the local county crisis line or by dialing 911.

Necessity of In-Person Evaluation: A variety of alternative methods of clinical care may be available. A client may request alternative methods of care to telehealth from Treatment Provider. Telehealth-based services and care may not be as complete as face-to-face services. There are potential risks and benefits associated with any form of treatment, and that despite client efforts and the efforts of Treatment Provider, a condition may not improve, and in some cases may even get worse. If it becomes clear that the telehealth modality is unable to provide adequate treatment, the Treatment Provider will make recommendations to the client for further care.

Telehealth Informed Consent

By signing this form, I understand/agree the following:

1. I am 18 years old or older.
2. I understand that telehealth is the use of electronic information and communication technologies by a healthcare provider used to deliver services to an individual when he/she is located at a different location or site than I am.
3. I understand that the telehealth visit will be done through Doxy.me, a two-way video link-up. The healthcare provider will be able to see my image on the screen and hear my voice. I will be able to hear and see the healthcare provider.
4. I understand that the HIPAA laws that protect privacy and the confidentiality of clinical/medical information also apply to telehealth. I understand that the information disclosed by me during the course of my treatment is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including but not limited to:
    a. information demonstrating a probability of imminent physical injury to myself or others;
    b. suspicion of abuse of a child, elder, or individual with a disability; and
    c. if my clinical records are subpoenaed by a judge.
5. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
6. I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.
7. I understand that in the event of an adverse reaction to the treatment, or in the event of an inability to communicate as a result of a technological or equipment failure, I shall seek follow-up care or assistance at the recommendation of my Treatment Provider.
8. I agree to provide verification of Texas residency and inform my Treatment Provider immediately of any changes to residency.
9. I agree to secure a non-public environment for the duration of my telehealth sessions, including, but not limited to the following criteria: quiet, well-lit, enclosed area with minimal distractions and headphones/earbuds available. I will ensure confidentiality of my sessions by attending in a private setting.
10. I understand that there are risks and consequences associated with telehealth including, but not limited to the possibility, despite reasonable efforts on the part of my counselor/therapist/ intern, that the transmission of my medical information could be disrupted or distorted by technical failures. In addition, I understand that telehealth-based services and care may not be as complete as face-to-face services. I also understand that if my counselor/therapist/clinical intern believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services) I will be referred to a counselor/therapist who can provide such services in my geographic area.
11. I understand that Counseling Solutions may not provide telehealth services to me if I am outside of the State of Texas, and I understand that I may access telehealth services from Counseling Solutions from within the State of Texas only.
12. I understand that I have a right to access my mental health information and copies of medical records in accordance with Texas state law. I have read and understand the information provided above. I have discussed it with my counselor/therapist/clinical intern, and all of my questions have been answered to my satisfaction. My signature below indicates my informed and willful consent to treatment using this platform.
13. I understand that I will be responsible for any payment, copayment, or coinsurance that apply to my telehealth services.
14. I understand that by signing this form that I am consenting to receive health care service via telehealth.

Client Consent to the Use of Telehealth:

I have read and understand the information provided above regarding telehealth, and understand I have the opportunity to discuss it with my Treatment Provider. I hereby give my informed consent for the use of telehealth in my clinical care. I hereby authorize Counseling Solutions, and my Treatment Provider to use telehealth in the course of my diagnosis and treatment.

Print Client's Name: _____ DOB: _____ Age: _____

Address:_____ Email Address: _____

_____ Phone Number: (_____)_____

_____ _____

Client's Signature or if Minor Parent/Guardian's Signature Date