



**InSight Psychology and Behavioral
Health Services LLC**
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INFORMED CONSENT FOR TELETHERAPY SERVICES

Definition of Services:

Teletherapy is a form of psychotherapy provided via internet technology, which can include consultation, treatment, transfer of medical data, emails, telephone conversations and/or education using interactive audio, video, or data communications.

Minors:

If you are not an adult, we need the permission of your parent or legal guardian and their contact information for you to participate in teletherapy sessions. Your parent or legal guardian must review this document and agree to its terms.

Rights, Risks, and Responsibilities of Clients Participating in Telehealth Services:

1. I am a resident of Texas and must remain a resident of Texas while in treatment with my InSight psychotherapist. (This is a legal requirement for psychologists, LCSW's, LPC's, LMFT, LMFT-A's and LPC-Interns practicing in this state under a TX license.)
2. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
3. The laws that protect the confidentiality of my health information also apply to teletherapy. While I am participating in teletherapy, the information I disclose during the course of my therapy or consultation is generally confidential. However, if I am a danger to myself, others, or if there is suspicion of child abuse or neglect, elder abuse or neglect, this information must be reported to the appropriate authorities by my psychotherapist.
4. I understand that there are risks and consequences of participating in teletherapy, including, but not limited to, the possibility, despite best efforts to ensure high encryption and secure technology on the part of my psychotherapist, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.
5. There is a risk that services could be disrupted or distorted by unforeseen technical problems.

6. In addition, I understand that teletherapy based services and care may not be as complete as face-to-face services. I also understand that if my psychotherapist believes I would be better served by another form of therapeutic services (e.g. face-to-face services) I will be transitioned to that modality or referred to a professional who can provide such services in my area.

7. I understand that I may benefit from teletherapy, but that results cannot be guaranteed or assured. I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not improve, and in some cases may even get worse.

8. I accept that teletherapy does not provide emergency services. If I am experiencing an emergency, I will call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1.800. 273.TALK (8255) for free 24-hour hotline support. I can also call the local Psychiatric Emergency Services at (512) 472-4357. If I feel that I do not have sufficient impulse control to refrain from acting on my suicidal thoughts, I agree to notify my emergency contact and/or call 911 or one of the resources listed above.

Individuals who are actively at risk of harm to self or others are not suitable for teletherapy services.

If this is the case or becomes the case in future, my psychotherapist will recommend more appropriate services.

9. I understand that there is a risk of being overheard by anyone near me if I am not in a private room while participating in teletherapy. I am responsible for (1) providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions, and (2) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session. It is the responsibility of the psychotherapy treatment provider to do the same on their end.

10. I understand that dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent.

11. I agree to use the video-conferencing platform selected for our teletherapy sessions, and the psychotherapist will explain how to use it.

12. I understand that I will need to use a webcam or smartphone during the session.

13. I understand that it is important to use a secure internet connection. I understand that free Public/Wi-Fi may not be secure, and I should avoid using it for teletherapy sessions.

14. I understand that I am expected to be on time. If I need to cancel or change my teletherapy appointment, I must notify my psychotherapist 24-hours in advance by phone, text or email. **If I do not provide 24-hours' notice of cancellation, I will be charged a \$50 No Show fee.**

15. I will provide a phone number where I can be reached to restart the session or reschedule it, in the event of technical problems.

16. I will provide the contact information of at least one emergency contact.

17. I agree to confirm that my insurance company will reimburse my InSight psychotherapist for teletherapy sessions. If my insurance company does not reimburse my psychotherapist, I agree to make full payment for all non-reimbursed sessions.

18. I understand that my therapist will not record my session, nor will I record the session without permission from the other. I understand that it is not in my best interest to record teletherapy or face-to-face sessions.

I, _____, hereby consent to engage in teletherapy with _____ . I also understand that teletherapy involves the communication of my medical/mental health information, both orally and/or visually. Teletherapy has the same purpose or intention as psychotherapy that is conducted in person. However, due to the nature of the technology used, I understand that teletherapy may be experienced somewhat differently than face-to-face treatment sessions.

I have read, understand and agree to the information provided above regarding telehealth:

Client's printed name: _____

Client's Signature/Client's Legal Representative: _____ Date _____

Therapist's Signature: _____ Date _____