Information, Authorization & Informed Consent Addendum for Tele-Health

This is to be used in conjunction with, but does not replace, the Information, Authorization & Informed Consent for Treatment document that is required of all clients prior to starting therapy services. You may find a current version of the *initial* Authorization document on your therapist's web page.

TELEHEALTH

If telehealth services are necessary or requested, I hereby consent to engaging in telehealth as a part of the Elbow Tree Family of Business (Elbow Tree Christian Counseling, LLC; Elbow Tree Counseling and Neurofeedback; Christian Counselor Cooperative) as part of my psychotherapy. I understand that "telehealth" includes the practice of diagnosis, treatment, goal setting, referral to resources, skills training, and psychoeducation through the use of internet-based video-conferencing. Telehealth psychotherapy may include psychological health care delivery, consultation, coaching, and/or counseling. Telehealth psychotherapy will occur primarily through interactive audio, video, email, texting and telephone communications.

Confidentiality: I understand that the current laws that protect privacy and confidentiality also apply to telehealth. Any exceptions to confidentiality are described in the Authorization document. I understand that no permanent video or voice recordings will be made or kept from telehealth sessions. I agree not to record or store video conference sessions.

Technology: I understand that I may need to download an application and/or software to use this platform if my therapist requires it. I also need to have a broadband Internet connection or a smartphone device with a good cellular connection.

Risks: I understand telehealth carries risks, including but not limited to: a) technological failures such as unclear video, loss of sound, poor connection or loss of connection; b) nonverbal cues are less readily perceivable to both therapist and client; c) limits to confidentiality. At Elbow Tree Christian Counseling, we use HIPAA compliant and encrypted technology for a) sending and receiving email; b) performing audio and video sessions and c) creating and storing client records. Under certain circumstances, we may use unsecured technology for a) scheduling communications; b) to navigate emergent or crisis situations or c) when Federal Emergency Protocols are in place and services need to be delivered when HIPAA compliant systems are overwhelmed or unavailable.

Financial Obligations: Fees associated with telehealth appointments are payable by credit or debit card only and reflect my current regular session fee. If a superbill is desired to file for out-of-network benefits with my insurance company, I am responsible for contacting my insurance company to determine my coverage for telehealth services.

By initialing, I am indicating that I have reviewed the "Telehealth" policy and agree to its terms. _____

By signing below, I acknowledge that my clinician reviewed all aspects of this authorization for treatment and informed consent. I understand that I may ask questions at any time regarding any aspect of this Authorization and agree to abide by its terms during our professional relationship. I acknowledge a hard copy of this Authorization has been made available to me.

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Signature of Client (or Parent or Legal Guardian of Minor) Date