TELEMEDICINE/TELEHEALTH INFORMED CONSENT

I __________________________________ [name of client] hereby consent to engaging in telemedicine with Leslie Caffey, MA,LPC as part of my psychotherapy. I understand that "telemedicine" includes the practice of health care delivery, assessment, diagnosis, consultation, treatment, transfer of medical data, and psychoeducation using interactive audio, video, or data communications.

Technology: I understand that may need to download an application and/or software to use this platform. Platform to be determined and communicated from my primary therapist. (Some options: Doxy.me, Zoom, or other HIPPA compliant means) I also 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. I also understand that in case of technology failure, I may contact Leslie Caffey, MA, LPC via phone to coordinate alternative methods of treatment. Before session starts, I need to make sure all other applications are closed and that I am in a confidential location.

Financial Obligations: Fees associated with telemedicine appointments are payable by credit or debit card only. If fees may be associated with my telemedicine services, I agree to have my credit/debit card information on file with Leslie Caffey MA, LPC. My card will be billed the same day as my scheduled telemedicine appointment.

(Client Initial _________) I am aware of the fees associated with telemedicine appointments and agree to pay at the time of my appointment.

(Client Initial__________) I understand that I am responsible for cancelled telemedicine appointments in accordance with Leslie Caffey therapist policy as documented by my signature on the Informed Consent.

(Client Initial: _________) I understand that using the Telemedicine 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. (Client Initial: ________) In the event of a disconnection, if this results in your session lasting fewer than the allotted time, you will only be billed for time of your actual connection. In the event either of us are disconnected, your therapist will call you at the number she/he has on file, and we can continue via telephone.

Scheduling: I understand that scheduling is conducted through Leslie Caffey and is based on regular office hours. Telemedicine 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. Video/Audio Recording: As general practice telemedicine sessions are not recorded without prior permission.

Confidentiality: The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality including, but not limited to: reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. My therapist's platform is HIPAA compliant to protect my privacy and confidentiality.

I understand that I have the following rights under this agreement: 1. I understand that there are risks and consequences associated with telemedicine including, but not limited to the possibility, despite reasonable efforts on the part of my counselor/therapist/clinical intern, that the transmission of my medical information could be disrupted or distorted by technical failures. In addition, I understand that telemedicine-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 work with therapist to determine if we can do face to face or need to wait for the situation to pass.

2. **2. I understand that I may benefit from telemedicine but that results cannot be guaranteed or assured.**
3. **3. 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 my questions have been answered to my satisfaction. My signature below indicates my informed and willful consent to treatment using this platform.**
4. **4. I further understand that there are risks unique and specific to Telehealth, including but not limited to, the possibility that our therapy sessions or other communication by my therapist to others regarding my treatment could be disrupted or distorted by technical failures.**

5. 5. **I have read and understand the information provided above. I have the right to discuss any of this information with my therapist and to have any questions I may have regarding my treatment answered to my satisfaction.**
6. 6. **I understand that I can withdraw my consent to Telehealth communications by providing written notification to Leslie Caffey.**
7. 7. **In the event of a change, please let me know if you will be joining our session from a location other than your home. Please send the address of your new location for telehealth prior to our session beginning.**

My signature below indicates that I have read this agreement and agree to its terms.

Client Signature:____ Date:____