Compassion Clinic: Therapy Services

Consent to Telehealth Specific Treatment – use with Consent to Treatment Form

I consent to engaging in telehealth with Compassion Clinic: Therapy Services as a part of my treatment goals and the therapy process. I understand that telehealth psychotherapy may include mental health evaluation, treatment planning, therapy, and consultation. Telehealth will occur through interactive video, audio, telephone, and/or audio/video communications. We will be using Doxy.me and/or other HIPAA compliant software. I understand I have the following rights with respect to telehealth psychotherapy:

- The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information released by me during the course of my sessions is generally confidential to the best of the therapist's ability. There are other mandatory reporting issues that will limit confidentiality including but not limited to reporting child and vulnerable adult abuse, expressed imminent harm to oneself or others, or as part of legal proceedings where information is requested by a court of law. I also understand that the spreading of any personally identifiable images or information from the telehealth interaction to other entities shall not occur without my written consent.

- I have the right to withhold or remove consent at any time without affecting my right to future care or treatment, nor endangering the loss or withdrawal of any program benefits to which I would otherwise be eligible. However treatment will have to be halted until consent is given again.

- I understand that there are risks and consequences from telehealth including but not limited to, the possibility, despite reasonable efforts on the part of Compassion Clinic: Therapy Services that: the transmission of my personal information could be disrupted or distorted by technical failures and/or the transmission of my personal information could be interrupted by unauthorized persons.

- In addition, I understand that telehealth based services and care may not be as effective as in-person services. I understand that if my therapist believes I would be better served by other interventions I will be referred to an appropriate mental health professional who can provide those services in my area and/or return to in-person sessions with my therapist. I also understand that there are potential risks and benefits associated with any form of mental health treatment, and that despite my efforts and efforts of my therapist, my condition may not improve, or may have the potential to get worse.

- I understand that I may benefit from telehealth services, but that results cannot be guaranteed or assured, like any mental health therapy. I understand that the use of Compassion Clinic: Therapy Services designated telehealth platforms audio/video systems may not be 100% secure at all times and may have issues with Wi-Fi connectivity, even though telehealth systems are HIPAA compliant. All attempts to keep information confidential while using these systems will be made, but a guarantee of 100% confidentiality cannot be made with inherent issues with these communication systems. Signing this form shows an awareness of these issues and a decision by this client to use these systems for telehealth services. I will not hold Compassion Clinic: Therapy Services or its staff liable for gathering or use of client information by these service providers.

- I understand I have the right to access my personal information and copies of case notes. If you do request this, the therapist that is providing services will review the request and will discuss the pros and cons regarding the followthrough with this request; if it is assessed that having your information will be detrimental to your wellbeing this information will be told to you and the clinic will withhold your information. I have read and understand the information provided above. I have discussed these points with my therapist, and all of my questions regarding the above matters have been answered to my approval.

- By signing this document I agree that certain situations including emergencies and crises are inappropriate for audio/video/computer based therapy services. If I am in a crisis or in an emergency I should immediately call 911 or go to the nearest hospital or crisis facility. Therapists at Compassion Clinic: Therapy Services are not crisis workers, thus do not contact your therapist if you are in a crisis. By signing this document I understand that emergency situations may include thoughts about hurting or harming myself or others, if I am in a life threatening or emergency situation, and/or if I am abusing drugs or alcohol and are not safe. By signing this document, I acknowledge I have been told that if I feel suicidal I am to call 911, local county crisis agencies, or the National Suicide Hotline at 988.

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Signature of client/parent/guardian & relationship (if applicable) Date

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Printed name of client