ANDREWS & ASSOCIATES
COUNSELING

TELEHEALTH CONSENT FORM

I consent to engage in telehealth services with my therapist at Andrews & Associates Counseling. I understand that "telehealth" includes the practice of health care delivery, assessment, diagnosis, consultation, treatment, transfer of medical data, and psychoeducation using interactive audio, video, or data communications. I understand that, with my signed consent, telehealth may also involve the communication of my mental health information to other health care practitioners.

Technology: I understand that I may need to download an application and/or software to use this platform. I also need to have an Internet connection or a smart phone device with a cellular connection at home or at a location deemed appropriate for services. I also understand that in case of technology failure, I should call my therapist.

Insurance & Financial Obligations: I understand that I am responsible for contacting my insurance company to inquire about my telehealth benefits. I agree to provide payment based on this quote with a debit/credit card. I understand that if my insurance company does not pay for this service, I will provide payment to my therapist at the agreed upon rate.

Video/Audio Recording: Andrews & Associates Counseling DOES NOT record telehealth sessions without prior permission.

Confidentiality: I understand that the information disclosed by me during the course of my telehealth session 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 individual; and where I make my mental or emotional state an issue in a legal proceeding. Andrews & Associates Counseling telehealth application/software is HIPAA compliant to protect my privacy and confidentiality.

I understand that I have the following rights with respect to telehealth. I have the right to withdraw my consent at any time. 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 therapist, 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 therapist believes I would be better served by another form of psychotherapy services (e.g. face-to-face services) I will be referred to a therapist who can provide such services in my geographic area. I understand that I may benefit from telehealth, but that results cannot be guaranteed or assured. I understand that Andrews & Associates Counseling can not provide telehealth services to me if I am outside of the state of Kansas. I understand that I have a right to access my mental health information and copies of medical records in accordance with Kansas state law.

TELEHEALTH EMERGENCY INFORMATION

If you have a mental health emergency, I encourage you not to wait for communication back from me, but do one or more of the following:

- Call 911
- Go to your local emergency room
- Call Lifeline at (800) 273-8255 (National Crisis Line)

There are additional procedures that we need to have in place specific to Telehealth services. These are for your safety in case of an emergency and are as follows:

You understand that if you are having suicidal or homicidal thoughts, experiencing psychotic symptoms, or in a crisis that we cannot solve remotely, I may determine that you need a higher level of care and Telehealth services are not appropriate.

I require an Emergency Contact Person (ECP) who I may contact on your behalf in a life-threatening emergency only. Please enter this person's name and contact information below.

Either you or I will verify that your ECP is willing and able to go to your location in the event of an emergency. Additionally, if either you, your ECP, or I determine necessary, the ECP agrees take you to a hospital. Your signature at the end of this document indicates that you understand I will only contact this individual in the extreme circumstances stated above.

Please list your ECP: Name_____ Phone: _____

You agree to inform me of the address where you are at the beginning of every session. You agree to inform me of the nearest mental health hospital to your primary location that you prefer to go to in the event of a mental health emergency.

Please list your hospital: Name_____Phone: _____

You agree to inform me of the nearest police department to your primary location that you prefer to go to in the event of an emergency.

Please list police department: Address:_____Phone: _____

I have read and understand the information provided above. My signature below indicates my informed and willful consent to treatment using this platform.

Client Signature: _____ Date: _____
(If client is over the age of 12, client signs here.)

Responsible Party Signature (if applicable): _____Date: _____