

Teletherapy Informed Consent

Integrative Empowerment Group, PLLC

I _____ hereby consent to engage in teletherapy with the clinicians at Integrative Empowerment Group, PLLC. I understand that “teletherapy” includes clinical consultation, treatment, transfer of medical/clinical data, emails, and telephone conversations using interactive video, audio, or data communications. I understand that teletherapy also involves the communication of my medical/clinical information, both orally and visually. I understand that I have the following rights with respect to teletherapy:

- I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
- The laws that affect the confidentiality of my Protected Health Information (PHI), such as HIPAA, also apply to teletherapy. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential.
- However, there are both mandatory and permissive exceptions to confidentiality. These include:
 - If you, in writing, requires such disclosure;
 - If child abuse or neglect is disclosed, your clinician is required to notify the appropriate authorities;
 - If you seriously threaten or act in a way that indicates that you are very likely to harm yourself, your clinician might have to seek hospitalization for you, or call your emergency contacts. If such a situation does arise, your clinician will fully discuss the situation with you before taking action, unless there is a strong reason not to for the purposes of safety; If your clinician believes that another person is at risk if serious injury or death.
- I understand that there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of IEG and my clinician, 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 PHI could be accessed by unauthorized persons.
- In addition, I understand that teletherapy based services and care might not be as complete as face-to-face services. I also understand that if my clinician believes I would be better served by another form of therapeutic services (i.e. face-to-face services), I will be referred to a professional who can provide such services in my area.
- I understand that there are potential risks and benefits associated with any kind of psychotherapy, and that despite my efforts and the efforts of my provider, my condition might not improve, and in some cases, might get worse. I understand that I might benefit from teletherapy, but that results cannot be guaranteed.
- I accept that teletherapy does not provide emergency services. My provider and I will discuss an emergency response plan. If I am experiencing an emergency situation, I understand that I can 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 support.
- I understand that I am responsible for:
 - Providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions;
 - Providing accurate information to my clinician about my location while receiving teletherapy services;
 - The information security on my computer; and
 - Arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy sessions.
- I understand that while email may be used to communicate with my clinician, confidentiality of email cannot be guaranteed.
- I understand that I have a right to access my mental health information and copies of my clinical record in accordance with HIPAA privacy rules and applicable state law.

I have read, understand, and agree to the information provided above.

Client signature

Date

Witness signature

Date