West County Psychological Associates

Informed Consent for Telephone or Online Counseling Services

I _____ (name of adult client or child's legal guardian) hereby consent to engage in online and/or telephone therapy services for myself/my child through West County Psychological Associates (WCPA). I understand that online counseling/teletherapy may include consultation, therapy, assessment, diagnosis, transfer of medical data, telephone conversations, and education using interactive audio, video, or data communications. I understand that online counseling/teletherapy also involves the communication of my medical/mental health information, or that of my child, both verbally and visually.

I understand that I have the following rights with respect to online counseling/teletherapy:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.

2. The laws that protect the confidentiality of my medical information also apply to online counseling/ teletherapy. As such, I understand that the information disclosed by me during the course of my therapy or consultation is generally confidential. However, there are limits and exceptions to confidentiality with teletherapy, just as there are with in-person therapy. These include, but are not limited to, reporting child, elder, and dependent adult abuse and expressed threats of harm.

3. I understand that there are risks and consequences from online counseling/teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of WCPA that: the transmission of my information could be disrupted or distorted by technical failures, the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

4. In addition, I understand that online counseling/teletherapy based services and care may not be as complete as face-to-face services. My therapist cannot see me, my body language, or my non-verbal reactions to what we are discussing. My therapist may not hear all of what I am saying and may need to ask me to repeat and clarify more often than during face-to-face sessions. Confidentiality is not as assured as it may be during face-to-face services.

5. I understand that I may benefit from online counseling/teletherapy, but that results cannot be guaranteed.

6. I accept that online counseling/teletherapy does not provide emergency services. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help, or call my primary care physician or psychiatrist. 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) or text 741741 for free, 24 hour hotline support.

7. I understand that I am responsible for providing the necessary telephone or internet-connected devices and internet access for my online counseling/teletherapy sessions.

8. This is a professional service and I will treat it as such. I will arrange a location with sufficient privacy that is free from distractions or intrusions for my online counseling/teletherapy session. To the best of my ability, will focus my attention on the session similarly to the way I would in a live counseling session.

9. I understand that telehealth services through WCPA will only be conducted through telephone and/or online video services. Therapy will not be provided through email or text. Email and text communications with my therapist may only be used for setting appointments.

10. I agree that the telehealth testing services shall not be recorded in any way unless agreed to in writing by mutual consent. My clinician will maintain a record of our services in the same way (s)he maintains records of in-person services.

11. I understand that I have additional rights and responsibilities, which are outlined in the document *West County Psychological Associates Informed Consent for Therapy Services*, which I have also been provided.

By signing below, I acknowledge that I have both read and understood the information in this document and in *West County Psychological Associates Informed Consent for Therapy Services*, and agree to the terms of both documents. This consent ends when I notify my therapist that I am terminating telephone and/or online-based therapy or one year following my last therapy session.

Adult Clients:

Name of Adult Client(s): _____

Signature of Adult Client(s):

_____ Date: _____

_____ Date: _____

Minor Clients:

In the case of a minor client, the signature of a parent is required.

NOTE: If parents are divorced or legally separated, the signatures of both parents are required unless otherwise stated in the legal parenting plan.

Name and Age of Minor Client(s): _____

Signature: _____ Date: _____

Signature: _____ Date: _____