

Wellspring Counseling Center

FUMC Plano

Plano, Texas 75074

TELETHERAPY INFORMED CONSENT

I, _____, hereby consent to engage in Technology Assisted Services (TAS or teletherapy, e.g. internet or telephone-based therapy) for myself/child with my Wellspring counselor. I understand that TAS includes the practice of health care delivery, including mental health care, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, and /or data communications. I understand that TAS also involves communication of my medical/mental health information, both orally and visually.

I understand that I have the following rights with respect to TAS:

1. I may decline any TAS at any time without jeopardizing my access to future care or services.
2. The HIPAA laws that protect the confidentiality of my medical information also apply to TAS. I further understand that there are limits to confidentiality, just as there are with in-person therapy, such as reporting child, elder and special-needs adult abuse, expressed threats of violence; and expressed intent for self-harm.
3. I understand there are risks and consequences of TAS, including but not limited to disruption or distortion of medical information due to technical failures, breaches of confidentiality, or theft of personal information.
4. I further understand that TAS and care may not yield the same results nor be as complete as face-to-face service. I understand that if my therapist believes I would be better served by form of therapy, that will be offered to me through my current therapist or I will be referred to another therapist who can provide such service.
5. I understand that I may benefit from TAS, but that results cannot be guaranteed or assured. I further understand that there are potential risks and benefits associated with any form of therapy, and that despite my efforts and the efforts of my therapist, my condition may not improve and in some cases may

even worsen. The benefits of TAS may include: finding a better ability to express thoughts and emotions; transportation and travel difficulties diminished; time constraints minimized; greater opportunity to prepare in advance for therapy sessions.

6. I accept that TAS 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. I can also 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) for free 24-hour hotline support.

7. I understand that I am responsible for: (a) providing the necessary computer, internet access or telephone for my TAS sessions; (b) accessing the secure platform selected by my Wellspring counselor; (c) arranging for a location free of intrusions and distractions and with sufficient lighting and privacy.

8. I understand that the same HIPAA access to medical records applies for TAS as for in-person therapy.

9. I understand that in the event of disruption of services, or for any other reason that we might need to communicate by a different platform or means, my therapist will call or text (indicate which) me at the following number _____.

I have read and understand and have discussed the information provided above with my therapist and have also explored and questions I might have to my satisfaction.

Client/Minor Name: _____

Client/Parent Signature: _____ Date: _____

Client/Parent Signature: _____ Date: _____