Brighter Hope
Wellness Center

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TELEHEALTH/TELETHERAPY AGREEMENT

After intake and the establishment of a therapeutic relationship, it may be possible for treatment delivery to occur via interactive video-conferencing (i.e., virtual "face-to-face" sessions) in lie u of, or in addition to, "in-person" sessions. Video conferencing (VC) is a real-time interactive audio and visual technology that enables our clinicians to provide mental health services remotely. The VC system we use (www.doxy.me) meets HIPAA standards of encryption and privacy protection but we cannot guarantee privacy. You will not have to purchase a plan or provide your name when you "join" our online meeting.

Treatment delivery via VC may be a preferred method due to convenience, distance, or other circumstances. Although VC may be used when the clinician and client are in different locations, licensure regulations only allow a session to be conducted in the state in which the clinician is licensed and the client is located. An occasional exception can be made if temporary permission is available from another state. VC may also be used within our office location (room to room) for Parent Child Interaction therapy or other parent coaching.

Risks to VC in general may include (but are not limited to): lack of reimbursement by your insurance company, the technology dropping due to internet connections, delays due to connections or other technologies, or a breach of information that is beyond our control. Clinical risks will be discussed in more detail with your clinician, but may include discomfort with virtual face-to-face versus in-person treatment, difficulties interpreting non-verbal communication, and importantly, limited access to immediate resources if risk of self-harm or harm to others becomes apparent. Your clinician will weigh these advantages against any potential risks prior to proceeding with telehealth sessions and will discuss the specifics of telehealth with you before using the technology.

By signing the document below, you are stating that you are aware that your provider may contact the necessary authorities in case of an emergency. You are also acknowledging that if you believe there is imminent harm to yourself or another person, you will seek care immediately through your own local health care provider or at the nearest hospital emergency department or by calling 911. Below, please include the names and telephone numbers of your local emergency contacts (including local physician; crisis hotline; trusted family, friend, etc.).

_____

Physician or Psychiatrist Name & Relationship Telephone number(s)

_____

Crisis Hotline and local Crisis Center Names Telephone number(s)

Family Member Name & Relationship Telephone number(s)

Friend Name & Relationship Telephone number(s)

By signing this document you are declaring your agreement with the following statement:

I have read this document and have had the opportunity to ask questions. I have discussed this with my clinician and understand the risks/limitations and benefits of video conferencing. I agree to Telehealth sessions (CPT code includes the modifier of GT, GQ, or 95) via video conferencing.

Client Signature Date

Client Print Name

If for minor, Parent or Legal Guardian Signature Date

Parent/Legal Guardian Print Name(s)

Clinician Signature Date

Clinician Print Name