

TELEHEALTH INFORMED CONSENT

I, _____ (name of patient), hereby consent to engaging in telehealth with Michael Hollingsworth, LCPC, LLC as part of my psychotherapy. 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, both orally and visually, to other health care practitioners located in the state of Idaho.

I understand that using the telehealth platform allows access to mental health services that might not otherwise be available to me due to my mental health, and/or my physical, resource, or geographic limitations. I understand that this informed consent document is an addition to the informed consent document signed at the initial onset of services. I understand that the information in both this form, and the initial form, may apply to telehealth services.

Technology: I understand that I am responsible for (1) having a broadband internet connection or a smart phone device with a good cellular connection (2) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions (3) providing the clinician my full name and date of birth to confirm my identity at the beginning of each session (4) providing the clinician the address of my location and the phone number I can be contacted at. I also understand that in case of technology failure, I may contact Michael Hollingsworth, LCPC, LLC via phone at (208) 887-1911, ext 112 to coordinate alternative methods of treatment.

Clients Using Insurance: I am responsible for contacting my insurance company, if applicable, to determine what my out-of-pockets costs may be. I authorize insurance benefits to be paid directly to Michael Hollingsworth, LCPC, LLC. I also authorize Michael Hollingsworth, LCPC, LLC to release any information to my insurance provider required for processing my claims.

Self-Pay Clients: I am aware of the fees associated with telehealth appointments and agree to pay at the time of my appointment. I understand that I am responsible for canceled telehealth appointments in accordance with the cancellation policy as documented by my signature.

Scheduling: I understand that scheduling is conducted through Michael Hollingsworth, LCPC, LLC and is based on my provider's normal clinic hours. I understand that my counselor has the right to terminate the session at any time if any person other than myself is also present during the session without prior permission. Telehealth appointments are considered outpatient services and are not intended as a substitute for emergency or crisis services. Crisis or mental health emergencies should be directed to the local county crisis line or by dialing 911.

Video/Audio Recording: Michael Hollingsworth, LCPC, LLC DOES NOT record Telehealth sessions without prior permission. As the client receiving services I also agree to not record telehealth sessions without informing my provider.

Confidentiality: The laws that protect the confidentiality of my medical information also apply to telehealth. 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 including, but not limited to: reporting child, elder, and dependent adult abuse; safety concerns regarding myself or others; and where I make my mental or emotional state an issue in a legal proceeding.

Michael Hollingsworth, LCPC, LLC utilizes a telehealth platform that is HIPAA compliant to protect my privacy and confidentiality. This is further explained in the New Patient Paperwork, which I signed when initially starting services.

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

- 1) I have the right to withdraw my consent at any time without affecting my right to future care or treatment.
- 2) I understand the alternatives to counseling through telehealth as they have been explained to me, and in choosing to participate in telehealth, I am agreeing to participate using video/audio conferencing technology. 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 counselor, 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 understand that at my request or the direction of my counselor, I may be referred to another form of psychotherapeutic services (e.g. face-to-face services) who can provide such services in my geographic area.
- 3) I understand that I may benefit from telehealth but that results cannot be guaranteed or assured.
- 4) I understand that Michael Hollingsworth, LCPC, LLC may not provide telehealth services to me if I am outside of the State of Idaho, and I understand that I may access telehealth services from Michael Hollingsworth, LCPC, LLC from within the State of Idaho only.
- 5) I understand that I have a right to access my mental health information and copies of medical records in accordance with Idaho state law. I have read and understand the information provided above. I understand the risks and benefits related to the use of telehealth services and have had my questions regarding the procedure explained. My signature below indicates my informed and willful consent to treatment using this platform.

Printed Client Name: _____

Client Signature: _____ Date: _____

Guardian Signature (if applicable): _____ Date: _____