Upswing Counseling Teletherapy Informed Consent

This Informed Consent form is intended to inform you about ***Upswing Counseling*** policies and procedures regarding Teletherapy Services and to ensure your agreement to these services. Your signature on this form indicates that you, the client, acknowledge that you understand and agree that ***Upswing Counseling*** will provide therapy to you according to this Teletherapy Informed Consent form. The content below must be read, discussed with your therapist at the initial consultation (and any time thereafter as needed) OR before the start of any Teletherapy Services, and agreed upon before any Teletherapy services can begin. Please ensure that each section is read and reviewed carefully. If you have any questions or concerns, please discuss them with your therapist before obtaining any Teletherapy services. Please print a copy of this policy for your records and this policy can be available at any time if requested.

I understand that Teletherapy (also referred to as e-therapy, telehealth, virtual therapy or video therapy) is the use of HIPAA compliant electronic information and communication technologies (including video and audio technology) by a mental health provider to deliver services to an individual when they are located at a site that is different than their provider.

I understand that the Health Insurance Portability and Accountability Act (HIPAA) policies and laws that protect the privacy and confidentiality of my medical information also applies to Teletherapy. My rights to confidentiality with Teletherapy services are exactly the same as my rights for in-person therapy services.

There are also limits to confidentiality as dictated by law. Any information disclosed by me during the course of my therapy, therefore, is generally confidential, with the following exceptions:

- Mandatory reporting of child, elder, and dependent adult abuse.
- Any threats of violence I may make towards a reasonably identifiable person.
- If I am in such mental or emotional condition to be a danger to myself or others, my therapist has the right to break confidentiality to prevent the threatened danger.
- Under court order or subpoena, the provider may be required to disclose information to person(s) as directed by the order or subpoena.
- If an investigation is being conducted by a licensing board or other government entity, information may be disclosed as directed by that board or entity.

Therapeutic treatment for mental health, both in person and through Teletherapy services, has been found to be effective in treating a wide range of clients, individual results and responses to therapy may vary. By signing this form, I also understand that results of any therapy, whether in person or through Teletherapy services, cannot be guaranteed.

I further understand that there are risks unique and specific to Teletherapy, including but not limited to, the possibility that our therapy sessions or other communication by my therapist to others regarding my treatment could be disrupted or distorted by technical failures, could be interrupted, or could be accessed by unauthorized persons. If a disruption or an emergency situation occurs, my therapist can be contacted***. By signing this consent form, I am acknowledging that I know how to contact my provider in case of a disruption or emergency.***

Additionally, I understand that the capture (including screenshots or photos of the therapy session), saving, or dissemination of any personally identifiable images or information from the Teletherapy interaction to any other entities shall not occur without my explicit written consent. My therapist also agrees to under no circumstances take any personally identifiable images from the session or store any of these images on [his/her] own devices from Teletherapy sessions.

In accordance with our **Client Acknowledgment & Informed Consent** If you are unable to attend a scheduled appointment, you may be expected to pay a late cancellation fee unless you provide a 24 hours advance notice of cancellation (or unless we both agree that you were unable to attend due to circumstances beyond your control). It is important to note that insurance companies do not provide reimbursement for cancelled sessions.

Similarly, if I am late to my scheduled session, I will receive my service for the remainder of my scheduled session time slot without refund.

Also, due to certain licensing requirements I agree to be physically in Illinois each session and to give my current physical address accurately at the beginning of each session. As a parent of the designated minor child client, **I agree to tell the therapist at the beginning of each session if my child is having any suicidal or homicidal thoughts.**

I understand that Teletherapy appointments need to be conducted in a private and confidential space. I agree (unless otherwise agreed upon) to conduct my child's appointments in a private, spacious (not too small or too large, gives the child room to move around if needed), and secure room where I am available to assist when called upon. I will be prepared to do a "room scan" to ensure that my child and I are the only ones present in the room.

In the case that the client is a minor child, the child's parent or guardian agrees to help support their child in finding a confidential and private space. The parent also agrees to be either physically present at the location OR available via phone for the duration of the session and 15 minutes prior and after the scheduled session time. The parent must be willing and able to join the session at any time if requested.

I understand that I have the right to withhold or withdraw my consent to the use of Telemedicine services in the course of my care at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting my therapist.

I have fully read, understand, and agree to comply with the information provided above. I understand I have the right to discuss any of this information with my therapist and to have any questions I may have regarding my treatment answered to my satisfaction.

My signature below indicates that I have read this Telemedicine Informed Consent and agree to its terms. I hereby consent to participating in psychotherapy via Telemedicine Services via an online HIPAA compliant telemedicine platform with the clinician listed below:

Client Name (printed): _____ (or parent/guardian)

Client signature: _____ (or parent/guardian)

Therapist Signature: _____ Date:_____