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Telehealth Informed Consent

To better serve the needs of the community at this time, mental health and counseling services are now available by interactive video communication. This process is referred to as "telehealth". Telehealth involves the use of electronic communications to enable physicians and health care professionals (Treatment Provider" at different locations to share individual client clinical information for the purpose of improving client care. Treatment providers may include, but are not limited to counselors and marriage and family therapists. The information may be used for healthcare delivery, diagnosis, treatment, transfer of clinical data, therapy, consultation, follow-up and/or education, and my include client clinical records and live two-way audio and video. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of client identification and information. It is important that you understand and agree to the following statements.

Expected Benefits:

1. Improved access to healthcare by enabling client to remain at a remote site while consulting with Treatment Provider.
2. More efficient healthcare evaluation and management
3. Obtaining the expertise of a distant specialist.

Possible Risks
Although rate, there are potential risks associated with the use of telehealth. These risks include, but may not be limited to:

1. Information transmitted may not be sufficient (e.g. poor connections) to allow for appropriate clinical decision making by the Treatment Provider and consultant(s).
2. Delays in evaluation and treatment could occur due to technical deficiencies or failures;

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3. The transmission of client's clinical could be interrupted by unauthorized persons; and/or electronic storage of my clinical information could be accessed by unauthorized persons; and
4. A lack of access to complete clinical records may result in judgement errors.

Necessity of In-Person Evaluation:

A variety of alternative methods of clinical care may be available. A client may request alternative methods of care to telehealth. Telehealth based services and care may not be as complete as a face to face service. There are potential risks and benefits associated with any form of treatment, and that despite client efforts and the efforts of treatment provider, a condition may nor not improve, and in some cases may even get worse. If it becomes clear that the telehealth modality is unable to provide adequate treatment, the Treatment Provider will make recommendations to the client for further care.

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of clinical information also apply to telehealth. I understand that the information disclosed by me during the course of my treatment is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including but not limited to:
    a. Information demonstrating a probability of imminent physical injury to myself or others;
    b. Suspicion of abuse of a child, elder, or individual with disability; and
    c. If my clinical records are subpoenaed by a judge.
2. I understand that I have the right to withhold or withdraw my consent to use telehealth in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.
4. I understand that in the event of an adverse reaction to the treatment, or in the event of an inability to communicate as a result of a technological or

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equipment failure, I shall seek follow up care or assistance at the recommendation of my Treatment Provider.

5. I agree to provide verification of Texas residency and inform my Treatment Provider immediately of any changes to residency.
6. For Minors seeking treatment: I agree to verify guardianship of minors seeking treatment by providing requested documentation. Additionally, I confirm that the minor seeking therapy is 15 years of age or older.
7. I agree to secure a non-public environment for the duration of my telehealth sessions, including, but not limited to the following criteria: quiet, well lit, enclosed area with minimal distractions and headphones/earbuds available. I will ensure confidentiality of my sessions by attending in a private setting.

In case of life-threatening emergency, call 911 immediately

Please notify me for any concerns regarding your care. An individual who wishes to file a complaint against a Licensed Professional Counselor may write to: Texas State Board of Professional Counselors P.O. Box 141369 Austin, Texas 78714 or call 1-800-942-5540.

Client Consent to the Use of Telehealth
I have read and understand the information provided above regarding telehealth and understand I have the opportunity to discuss with my treatment provider. I hereby give my informed consent for the use of telehealth in my clinical care.

I hereby authorize Toni L Wood MS LPC to use telehealth in the course of my diagnosis and treatment.

_____ _____
Signature Date

_____ _____
Toni L. Wood Date