LACEY COUPLE & FAMILY THERAPY SERVICES, PLLC
677 WOODLAND SQUARE LP SE, SUITE 15, LACEY, WA 98503
360.588.2181

Lacey Couple & Family Therapy Service's

PLLC TELEHEALTH-PSYCHOTHERAPY INFORMED CONSENT

This Informed Consent for Telehealth-psychotherapy contains important information focusing on doing psychotherapy using the phone or the Internet. Please read this carefully, and let me know if you have any questions. When you sign this document, it will represent an agreement between us.

I _____ (name of the client) hereby consent to engaging in telehealth at Lacey Couple and Family Therapy Services, PLLC with Betsy Hicks MA., LMFT as part of my psychotherapy service. I understand that "telehealth-psychotherapy/telemedicine" includes the practice of health care delivery, assessment, diagnosis, consultation, treatment, transfer of medical data, texting, and psychoeducation using interactive audio, video, or data communications.

Benefits and Risks of Telehealth-psychotherapy: The laws that protect the confidentiality of medical information also apply to telehealth-psychotherapy. The extent of confidentiality and the exceptions to confidentiality that are outlined in the Informed Consent still apply in telehealth-psychotherapy. Telehealth-psychotherapy refers to providing services remotely using telecommunications technologies, such as video conferencing or telephone. One of the benefits of telehealth-psychotherapy is that the client and clinician can engage in services without being in the same physical location. This can be helpful in ensuring continuity of care if the client or clinician is unable to continue to meet in person. Telehealth-psychotherapy requires some technical competence. Although there are benefits of telehealth-psychotherapy, there are some differences between in-person psychotherapy and telepsychology, as well as some risks. For example:

Risks to confidentiality. Because telehealth-psychotherapy sessions take place outside of the therapist's private office, there is potential for other people to overhear sessions if one is not in a private place during the session. Telehealth-psychotherapy should only be while in area where other cannot overhear the conversation. With the nature of electronic communications technologies there is a risk to confidentiality and communications may be compromised, unsecured, or accessed by others. Reasonable steps should be made to ensure the security of communications (for example, only using secure networks for telepsychology sessions and having passwords to protect the device(s) used for telepsychology.)

Issues related to technology. There are many ways that technology issues might impact telepsychology. For example, technology may stop working during a session.

Efficacy. Most research shows that telehealth-psychotherapy is about as effective as in-person psychotherapy. However, some therapists believe that something is lost by not being in the same room. For example, there is debate about a therapist's ability to fully understand non-verbal information when working remotely.

Technology: I understand that I will need to download an application and/or software to use this platform & I will need to have a broadband Internet connection or a smart phone device with a good cellular connection at home or at the location deemed appropriate for services. In case of technology failure, during an appointed time, I will call my provider at Lacey Couple & Family Therapy Services, PLLC via phone at 360-588-2181 to complete the session. For communication between sessions, I understand email communication should be limited to scheduling, rescheduling, and cancellations purposes and my therapist will not respond to text messaging or social media platforms.

Financial Obligations: I understand I am solely responsible for entire fees for sessions and if I am seeking reimbursment from my insurance company, they may not cover sessions that are conducted via telecommunication or otherwise. The same fee/rates will apply for telehealth-psychotherapy as apply for in-person psychotherapy. I understand I am solely responsible for any cost to obtain any necessary equipment, accessories, or software on my end to take part in telehealth.I agree to have my credit/debit card information on file with Lacey Couple & Family Therapy Services, PLLC. My card

will be billed the same day as my scheduled Telehealth-psychotherapy appointment. If I do not cancel my appointment with 24 hours prior to scheduled time or 'no show' I will be charged in accordance with the cancelation policy.

Records and Release of Information: The telehealth-psychotherapy sessions shall not be recorded. Records will be maintained and documented of the telehealth-psychotherapy session in the same way they are maintained as if in-person sessions in accordance policies. Transmitted Data may become part of my medical record. The date and duration of time will be captured and documented. I will have access to all of the information in my medical record resulting from the telehealth-psychotherapy services that I would have for a similar in-person visit, as provided by federal and state law. All releases of information are subject to the same laws and regulations as in-person care.

Emergencies and Technology: Telehealth-psychotherapy appointments are considered outpatient services and not intended as a substitute for emergency or crisis services/situations that require high levels of support and/or intervention. If an emergency occurs during a telehealth-psychotherapy encounter, I should call 911 and stay on the video connection (if applicable) until help arrives. If the session is interrupted for any reason and I am having an having an emergency, I understand I need to call 911, or go to the nearest emergency room and call therapist back after I have called or obtained emergency services. I understand I need to verify my location at the start of the session and if I am having an emergency during the session, I agree to have Betsy Hicks contact 911 and/or an identified trusted contact person.

Rights: I understand that I have the following rights with respect to Mental Health and Telehealth-psychotherapy services.

1. I have a right to withhold or withdraw consent at any time. I have the option to refuse the delivery of health care services by telehealth-psychotherapy at any time without affecting my right to future care or treatment. I have the right to request alternate services such as an in-person appointment; however, I understand that equivalent in-person services might not be available at the same location or time as telehealth-psychotherapy services.
2. I understand that there are risks and consequences from telehealth-psychotherapy, including but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failure; the transmission of my medical information could be interrupted by unauthorized persons; and/or electronic storage of my medical information could be accessed by unauthorized persons. In addition, I understand that telehealth-psychotherapy-based services and care may not be as complete as face-to-face services. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services) I will be referred to a psychotherapist who can provide such services in my area.
3. I understand that I may benefit from telehealth-psychotherapy, but that results cannot be guaranteed or assured.

Client Consent to use Telehealth-psychotherapy for Therapy Service: This agreement is intended as a supplement to the general informed consent that we agreed to at the outset of our clinical work together and does not amend any of the terms of that agreement. My signature below indicates my informed and willful consent and agreeance with the terms and conditions outlined and to treatment using this platform. By signing this document, I attest that I have read, understand and consent to the terms and conditions above and that I consent to participating in the services provided by Lacey Couple & Family Therapy Services, PLLC.

_____

Client Name Signature Date

_____

Therapist Signature Date

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