Consent to Treat Via Tele-therapy

1. Purpose: The purpose of this form is to obtain your consent to participate in tele-therapy in connection with your outpatient therapy treatment and to outline expectations for tele-therapy sessions.

2. Nature of Tele-therapy: Tele-therapy is similar to in person therapy, in that it is a private therapeutic session between you and your therapist. The difference is that the therapy is conducted via an online platform with live two-way audio and video, so that both parties can meet despite being in different locations. While in-person sessions are the preferred modality for this agency, we understand that under certain situations, it is not possible and tele-therapy is the best alternative. BHWC will ensure that the online system used for tele-therapy is HIPAA compliant and secure.

3. HIPAA and Recording Sessions: All information shared by you and any material kept in your file will remain confidential, unless you give permission for its release or there is legal requirement for its release. Please do not share transcripts of interactions nor record (either audio or video) counseling interactions without your therapist's written consent. The therapist will not record (either audio or video) without written consent. As your therapist is a Mandated Reporter, understand that any information you provide that indicates that you may be a risk to yourself or others, must be appropriately reported, just as in an in-person session.

4. Risks: There are risks associated with participating in tele-therapy including loss of information, hacking or the session may have to be rescheduled due to technical failures. Your therapist may be unable to provide appropriate interventions and guarantee your safety should you experience a crisis or safety issues during the tele-therapy session.

5. Your Responsibilities: You are expected to be on-time for sessions, provide prior notification if you are unable to participate in a session and will be charged according to agency policy, should you miss a session without appropriate notification. It is your responsibility to ensure you are in a private space where you can speak freely and to inform the therapist if you are unable to do so or if there are others that are with you during session. Just like an in-person session, it is expected that you be dressed and not engaging in any activities that you would not engage in during an in-person session. It is your responsibility to be in a fixed location (not in a moving vehicle). It is your responsibility to ensure that you have the technological understanding and equipment needed to engage in tele-therapy, which will usually be a smart phone or computer that has a microphone and camera. Should your insurance company not cover tele-therapy with your therapist, it is your responsibility to pay for the session. It is your responsibility to ensure that you are in the state of Virginia at the time the service is rendered and to inform your therapist of your exact location.

6. Rights: You may withhold or withdraw consent to the teletherapy session at any time without affecting your right to future care of treatment. I understand that this policy is in addition to, not instead of, the HIPAA and Office Policies that I have already signed.

7. Disputes: You agree that any dispute arriving from the tele-therapy session will be resolved in Virginia and that Virginia law will apply to all disputes.

8. Risks, Consequences and Benefits: You have been advised of all potential risks, consequences and benefits of tele-therapy. Your therapist has discussed with you all the information provided above. You have had the opportunity to ask questions about the information provided on this form and tele-therapy. All your questions have been answered and you understand the written information provided above.

I agree to participate in tele-therapy with my therapist and to the above policy:

- [x] By checking this box, I agree to use electronic records and signatures and I acknowledge that I have read the related consumer disclosure. (required)

Please type your name to sign below	Date
sample test	05/19/2023

- [ ] I am the parent/guardian of this patient

X *sample test* 05/19/2023