Consent to Telehealth
Hopkins Counseling Services, LLC

I, _____, consent to participate in counseling and/or assessment sessions via conferencing (i.e., teletherapy) as described below.

I understand that Hopkins Counseling Services, LLC, cannot and does not guarantee the privacy or security of any session content or communication conducted via telephone or video conferencing. Although the teletherapy software utilized is secure and HIPAA compliant, there is always potential that video conferencing sessions or phone calls could be intercepted by others, and I understand that communicating via these mediums is not 100% secure. I will not hold Hopkins Counseling Services responsible for any breaches of privacy or security that occur during video conferencing contact.

I understand that video conference sessions may be recorded and reviewed by my counselor and her supervisor, and deleted in a timely manner.

I understand that my counselor will continue to preserve client confidentiality with teletherapy by being in a completely private location, ensuring no outside distractions occur to the best of their ability, etc.

I understand that at the start of each telehealth session my counselor will confirm the address of my location should a situation arise that necessitates emergency personnel being sent to the me. If, during a telehealth session, I (or another member of my household) am suspected of being at imminent risk of harming themselves, my counselor will instruct me to dial 911 or go immediately to the nearest emergency department. My counselor will call 911 and disclose my address to emergency responders if I do not, or if I am unable to do so. Similarly, if my counselor believes I (or another household member) am an imminent danger to someone else, they will notify necessary authorities to ensure everyone's safety.

Should a situation arise in which a 911 call is not necessitated, but in which my counselor feels should be handled by a supervisor, my counselor will inform me that they are contacting their supervisor and ask me to wait on the teletherapy session for the supervisor to join. My counselor will then call the supervisor by phone to inform them of the situation, and then send the supervisor a link to join our session.

I understand that if I choose to have a counseling or assessment session using teletherapy, my counselor will email me an invitation with a link embedded in it before our session. I will simply click on the link on my computer or smartphone, or dial in to the phone number provided through the email, to begin our session. I understand I should be in a quiet and completely private room when our session is occurring, and that if I am unable to do so, my counselor will reschedule our session.

Technological difficulties can occur during the provision of clinical services by videoconferencing. To minimize these technological difficulties, I understand I should:

- Test the link before the scheduled session.
- Use a hardwired connection (via LAN cable) rather than a wireless connection when possible to increase audio and video quality.
- Ensure my electronic device is fully charged or plugged in before a scheduled session.
- Be online a few minutes prior to the scheduled session.
- Attempt to reconnect with my counselor immediately if an ongoing teletherapy session is interrupted/disconnected. If reconnection cannot occur, my counselor and I will attempt to reschedule the session through email communication.
- Consider using headphones as an extra layer of privacy.

I have been informed of and understand the risks and procedures involved with using teletherapy. I agree to the terms listed above and I hereby voluntarily consent to the use of teletherapy with my provider. I agree that Hopkins Counseling Services, LLC, should not be held liable in the event that any outside party passes technology security and discovers personal or confidential information. This consent will last for the duration of the relationship with this clinic unless I explicitly withdraw my consent for teletherapy session – which I am allowed to do at any time and for any reason – and my clinician will work with me to find a suitable alternative.

Client Name: _____

Date of Birth: _____

Address: _____

E-Signature of Client or Parent/Guardian: _____ Date: _____

Signature of Counselor: _____ Date: _____