**![A black and blue text

Description automatically generated]()**

**Telehealth Informed Consent**

I consent to engaging in Telehealth with **Best Practice Psychotherapy, LLC** as a part of the psychotherapy process. I understand that Telehealth Psychotherapy may include mental health evaluation, assessment, consultation, treatment planning, and therapy. Telehealth will occur primarily through interactive audio and video. I understand that I have the following rights with respect to Telehealth:

I have the right to withhold or remove consent at any time without affecting my right to future care or treatment.

The HIPPA laws that protect the confidentiality of my personal information also apply to Telehealth. As such, I understand that the information released by me during the course of my sessions is generally confidential. There are both mandatory and permissive exceptions to confidentiality including but not limited to; reporting child and vulnerable adult abuse, expressing imminent harm to oneself or others, or as a part of legal proceedings where information is requested by a court of law. I also understand that the dissemination of any personally identifiable images or information from the Telehealth interaction to other entities shall not occur without my written consent.

I understand that there are risks and consequences from Telehealth including but not limited to, the possibility, despite reasonable efforts on the part of **Best Practice Psychotherapy, LLC** that: the transmission of my personal information could be disrupted or distorted by technical failures and/or the transmission of my personal information could be interrupted by unauthorized persons. In addition, I understand that Telehealth-based services and care may not be as complete as in-person services in some instances. I understand that if my therapist believes I would be better served by other interventions I will be referred to a mental health professional who can provide these services in my area.

I understand that **Best Practice Psychotherapy, LLC** will use Doxy.me which is an approved HIPAA compliant software for Telehealth services. All clients who agree to Telehealth must visit Doxy.me/Charmaine for each virtual therapy session. Acknowledging receipt of this document shows an awareness of these issues and a decision by this client to use this system for Telehealth services. I will not hold **Best Practice Psychotherapy, LLC** liable for gathering or use of client information by this service provider.

I agree that certain situations including emergencies and crises are inappropriate for audio/video/computer-based psychotherapy services. If I am in crisis or experiencing an emergency, I should immediately call 911 or go to the nearest hospital or crisis facility. By acknowledging receipt of this document in writing, I understand that an emergency situation may include thoughts about hurting or harming myself or others, having uncontrolled psychotic symptoms, if I am in a life threatening or emergency situation, and/or if I am abusing drugs or alcohol and are not safe. I acknowledge I have been told that if I feel suicidal, I will call 911, local county crisis agencies, or the National Suicide Hotline at 1-800-784-2433.

Please sign and date below to acknowledge receipt of this document.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_