

Out Stretched Hands Counseling Center, LLC (OSHCC)
Consent for Telemental Health Services (Teletherapy)

Out Stretched Hands Counseling Center's services work through encrypted video software that allows the client ("you") to connect with your therapist through electronic means. Your therapist will be in another physical location and connect with you through a private virtual room. Your therapist will be a licensed professional and will be in the same state as you. When the session begins, the therapist will be able to see and hear you through the camera and microphone on your smartphone, computer, or tablet and you will be able to see and hear your therapist on their end through the same means. Your therapist, at any time, may determine that it be more appropriate for you to see a therapist in-person and therefore not appropriate for Teletherapy Group's services. Email may be used to transfer information such as receipt of payment, clinical materials and reminders for appointments.

POTENTIAL BENEFIT:

Out Stretched Hands Counseling Center will allow you increased access to care, improved participation, and feeling more comfortable in the private environment of your choosing. There is no travel time to appointments. You will be able to select your therapist based on your comfort level and their areas of expertise.

POTENTIAL RISK:

By using electronic means to meet with your therapist, there are limits to client confidentiality. There are security risks regarding unintended breaches of personal information when using online technology. If a breach of information is identified, you will be contacted. There is also the possibility of technology failure on your end or ours, which may result in the inability to complete the session or evaluation with your therapist. In that case, your therapist may attempt to contact you by phone. Traditional means of therapy also allow the therapist to read non-verbal cues and this becomes more difficult through electronic means. Your therapist will also be keeping therapeutic session notes that will be encrypted and securely stored as part of your medical record.

You, or a member of your family, are about to become involved in teletherapy services with a licensed therapist at Out Stretched Hands Counseling Center. Please take the time to review this information, so that we may continue to have a transparent and healthy therapeutic relationship.

1. **INITIAL INTERVIEW:** Your first visit is considered a diagnostic or evaluation interview. At the time of this appointment, the following decisions will be made with you:
 - A. type of therapy needed (individual, group, family, etc.)
 - B. frequency of therapy sessions (weekly, biweekly, etc.)
 - C. goals of therapy (what you hope to gain from this process.)
 - D. appropriateness for teletherapy (could you be better served in another environment)

2. **APPOINTMENTS:** Each appointment is approximately 45-55 minutes. At the end of each appointment, you can discuss future appointments with your therapist. You will also have access to scheduling by logging into your account and clicking the scheduling tab.

3. **EMERGENCY PROCEDURES:** If you, or a family member, are in crisis, please call the immediate services number for your home state or the crisis/suicide hotline 1-800-273-TALK or

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1-800-784-2433. If there is an emergency, please call 911 or go to your nearest emergency room for an immediate psychiatric evaluation.

4. **PAYMENTS:** Payment is charged to your credit card in full for each teletherapy session when you begin the session with your therapist. If your card is declined, you will not be able to start your session until a valid credit card is entered in the personal information section of your profile. In the case of minor children, the parent or guardian initiating treatment and signing below will be held financially responsible for all payments. **THERE ARE NO EXCEPTIONS TO THIS POLICY.** You have the right to dispute charges and must do so in writing to the address listed for Out Stretched Hands Counseling Center in the Terms and Conditions section within 30 days of the disputed charge. We reserve the right to deny any changes requested for charges incurred by the client or on behalf of the client.

5. **INSURANCE:** Out Stretched Hands Counseling Center **does not** currently contract with private or government insurers.

6. **CONFIDENTIALITY:** All information regarding the specific nature of your teletherapy is maintained at Out Stretched Hands Counseling Center, LLC and is considered confidential within the office unless specified by you in writing. However, each therapist at Out Stretched Hands Counseling Center reserves the right to use specialty consultation with other therapists at Out Stretched Hands Counseling Center as deemed necessary.

7. **COPY OF MEDICAL RECORDS:**

There is a medical records handling charge of \$25.00 per request to release records to cover the cost of time, and copies and postage for closed charts. An Authorization to Release Medical Records is required in order to release records.

I understand that this information is considered “Protected Health Information” under HIPAA and therefore by my acceptance below, I am waiving my right to keep this information completely private and requesting that it be handled as I have noted in this document.

As a client who uses Out Stretched Hands Counseling Center

I understand that I have the ability to withdraw consent to teletherapy services through Out Stretched Hands Counseling Center, LLC at any time.

I consent to receive therapy services through electronic means. I am aware that information transmitted electronically has security risks and flaws associated with the transmission and storage of information.

I understand that I will not be in the same physical location as my therapist.

I understand that I may decide to change therapists at any time for any reason.

I understand that my credit card will be charged at the time of service and will be charged a \$25 fee if I no-show for an appointment. This may include times that I fail to locate an adequate Internet connection that would allow for services to be provided at my scheduled appointment time.

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I understand that it is my responsibility to have access to an Internet connection and have a working camera on my smartphone, computer, or tablet.

I understand that I waive any confidentiality protections if I am in a public space or have others present near me while using Out Stretched Hands Counseling Center's services. I also waive confidentiality protections if others have or gain access to my phone, computer, or tablet.

I authorize the release of relevant medical information to third party payers and/or healthcare insurance companies for continuation of care. My medical information will never be sold in any way.

I have read this document and understand the benefits and risks of teletherapy, and I have had my questions regarding this process explained, and I hereby consent to participate in teletherapy sessions under the conditions described in this document.

Client Signature

Date