**Kay Atchison, LCSW, ACS**W

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**Teletherapy Informed Consent**

I , (name of client) hereby consent to participate in teletherapy with Kay Atchison, LCSW (name of provider) as part of my psychotherapy. I understand that teletherapy is the practice of delivering clinical care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations.

I understand the following with respect to teletherapy:

1)  I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.

2)  I understand that there are risk and consequences associated with teletherapy, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

3)  I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

4)  I understand that the privacy laws that protect the confidentiality of my protected information (PHI) also apply to teletherapy unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional as an issue in a legal proceeding).

5)  I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that teletherapy services are not appropriate and a higher level of care is required.

6)  I understand that during a teletherapy session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call me at 919-846-3455 to discuss as we may have to re-schedule.

7) I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

**Emergency Protocols**

Your location must be known in case of an emergency. You agree to inform me of the address where you are at the beginning of each session. I also need a contact person who I may contact on your behalf in a life- threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

In case of an emergency, my location is: and

emergency contact person’s name, phone:

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction. I, therefore, consent to the use of teleotherapy.

Client/Parent/Legal Guardian /Date

Therapist Signature /Date