SCW Psychological, Inc.

Teletherapy Agreement & Informed Consent Form

I, _____, hereby consent to engage in teletherapy, coaching, or consultation services with the providers at SCW Psychological, Inc. I understand that "teletherapy" includes clinical consultation, treatment, transfer of medical/psychiatric data, emails, telephone conversations and education using interactive audio, video, or data communications. I understand that teletherapy also involves the communication of my medical/psychiatric information, both orally and visually. I understand that I have the following rights with respect to teletherapy:

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

2. The laws, such as HIPPA, that protect the confidentiality of my medical information also apply to teletherapy. Accordingly, I understand that the information disclosed by me during teletherapy is confidential. Notwithstanding this confidentiality, there are both mandatory and permissive exceptions which may lead to disclosure, these include:

    a. If I, in writing, require such disclosure;

    b. If child abuse or neglect is disclosed, my provider may be required to notify the appropriate State or local agency responsible for child and family welfare and/or services;

    c. If I seriously threaten or act in a way that indicates that I am likely to harm myself, my provider may have to seek my hospitalization, or contact my family members or others who can help protect me. Unless there is a strong reason not to do so for safety reasons, if such a situation does arise, my provider will fully discuss the situation with me before taking action; and

    d. If my provider believes that another person is at risk of serious injury or death.

3. I understand that there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite diligent and reasonable efforts on the part of SCW Psychological, Inc., that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

4. I understand that my provider is licensed to provide therapy and teletherapy services in the States of Florida and North Carolina. Because my provider is located in the State of North Carolina while providing services, teletherapy services shall be deemed to have been provided in North Carolina and shall be governed by the laws of North Carolina. My teletherapy sessions shall have the same effect as visiting my providers office in North Carolina.

5. I understand that teletherapy based services and care may not be as complete as face-to-face services. I further understand that if my provider believes I would be better served by another form of therapeutic services (e.g. face-to-face services), I will be referred to a professional who

can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my provider, my condition may not be improved, and in some cases may even get worse. I understand that I may benefit from teletherapy, but that results cannot be guaranteed or assured.

6. I accept that teletherapy does not provide emergency services. During our first session, my provider and I will discuss an emergency response plan. If I am experiencing an emergency, I understand that I can and should call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at (800) 273–TALK (8255) for free 24-hour hotline support.

7. I understand that I am responsible for the following: a) providing the necessary computer, telecommunications equipment, and internet access for my teletherapy sessions; b) the information security on my computer; and c) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session.

8. I understand that while email and other electronic methods may be used to communicate with my provider, the confidentiality of these communication methods, even with reasonable diligence, cannot be guaranteed.

9. I understand that I have a right to access my medical/psychiatric information and copies of medical records in accordance with HIPAA privacy rules and applicable state law.

10. If I reside in a state other than my provider's state of professional licensure, I understand and agree that I am soliciting the services of a professional outside of my state of residence. By doing this, I agree that the "point-of-service" of therapy is to occur in my provider's state of professional licensure, and that I am using my computer/telecommunications device to virtually travel to that state. Accordingly, my provider is accountable to and agrees to abide by the ethical and legal guidelines prescribed by their state of professional licensure. By agreeing to solicit the out-of-state provider's services, I agree to these terms.

I have read, understand, and agree to the information provided above. To the extent I have questions, I have discussed them with my provider and any teletherapy session after the date of this agreement and consent confirms that any questions have been answered to my satisfaction

_____ _____

Signature of Client (or parent/guardian) Date