**FREEDOM'S HOPE COUNSELING, LLC**
**TELEHEALTH INFORMED CONSENT**

I, _____, agree to participate as a client of Freedom's Hope Counseling, LLC, telehealth delivery system. I will be receiving mental health services through interactive videoconferencing. I understand the use of videoconferencing is an alternative method of mental health care delivery and that my therapist will not be physically in the same room with me.

I understand that although Freedom's Hope Counseling, LLC, makes every effort to protect my privacy by using a secure server, they cannot guarantee the security of any information I transmit to them over the internet. By using telehealth services, I recognize that transmissions over the internet are at my own risk and that third parties may unlawfully intercept or access the transmissions. I also understand that despite reasonable efforts on the part of my therapist, there are risks and consequences in using telehealth services. The risks include, but are not limited to, the possibility that the transmission of sessions could be disrupted or distorted by technical failures. In case of technical failures, my therapist will make every effort to re-connect with me my preferred telephone number utilizing the pre-arranged ID authentication.

I also understand that telehealth services may not be as complete as services provided via face-to-face, although, several benefits of telehealth services have been identified including increased access to specialized services in remote areas, lower healthcare costs, reduced travel, minimizing time off work, and decreased waiting time for services. I have also been notified that if my therapist believes I would be better served by another form of counseling services (e.g., face-to-face services), I will be requested to meet in Freedom's Hope Counseling, LLC, offices face-to-face. Finally, I understand that there are potential risks and benefits associated with any form of mental health services and that, despite my efforts and the efforts of my therapist, my condition may not improve and in some cases may even get worse. I understand that my participation in this is voluntary and I may decide to terminate my treatment at any time. My privacy and confidentiality will be protected.

I understand that there will be no recordings of my therapist sessions. I also agree to not record my own therapy sessions without my therapist's knowledge or permission.

I understand that the telehealth services will be provided free of charge.

I understand that it is the therapist's responsibility initiating the teleconferencing utilizing a HIPPA compliant secure internet connection via email confirming the date and time of the appointment. I understand that if I do not attend the verbally agreed upon teleconferencing appointment, I will be held accountable to pay any no show fees as discussed in the standard Client Disclosure Statement and Consent form.

I understand that it is my responsibility to ask questions about anything I do not understand, find confusing or upsetting during a session to verify that I am understanding what the therapist is communicating. The therapist will make every effort to communicate any potential misunderstandings perceived during the session.

I understand that I will need to verify with my therapist of my location at the time of the conference for my safety and the legal obligations of the therapist. I also understand that it is my responsibility to admit myself into a Crisis Center or dial 911 should I become suicidal during a teleconferencing session. I understand that the purpose for using a teleconference session, in lieu of a face-to-face session, will be clearly stated, understood and agreed upon at the beginning of each teleconferencing session (e.g., due to inclement weather or extended illness).

I understand that face-to-face counseling sessions are preferred for long-term care. I understand that the purpose of teleconferencing will be utilized during my care for temporary or unexpected interruptions and expect face-to-face counseling to resume as soon as physically possible.

I understand that my health insurance may not cover psychotherapy services provided through teleconferencing.

I understand that all duties to warn explained in the signed Disclosure Statement apply in teleconferencing sessions and my therapist will be required by law to report any dangers to self, others, national security, or neglect and harm to children or elderly.

I understand that I am responsible to attend any teleconferencing sessions completely sober from any legal or illegal substances that are not prescribed by a physician or psychiatrist.

I give my consent to receive mental health services through Freedom's Hope Counseling, LLC's, telehealth system. I also understand that the services I receive will become part of record at Freedom's Hope Counseling, LLC, and will also be kept on file at Freedom's Hope Counseling, LLC.

_____ _____

Client Signature Date

_____

Client's Preferred Phone # in case of Teleconferencing Interruption

Connie Mitchell, MA, LPC, TMHC, NCC

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