**ELLIS COUNSELING, LLC**

**Informed Consent for Teletherapy Services**

Thank you for your interest in teletherapy services through Ellis Counseling, LLC.

By signing this form, I hereby consent to engage in teletherapy with my provider at Ellis Counseling, LLC. I understand that teletherapy includes treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that teletherapy also involves the communication of my medical/mental health information, both orally and visually.

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 that protect the confidentiality of my medical information also apply to teletherapy. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, which are discussed in detail in the general Informed Consent for Counseling Services I have previously received and signed.
3. I understand that there are risks associated with teletherapy services despite reasonable efforts taken to prevent such risks (including the use of a HIPPA-compliant teletherapy service). These include, but are not limited to, the possibility of disruption or distortion of my information due to technical failures; interruption of my information by unauthorized persons; and/or access of electronic storage of my medical information by unauthorized persons.
4. I understand that teletherapy based services and care may not be as complete as face-to-face services. I also understand that if I would be better served by another form of therapeutic services (i.e. face-to-face services), teletherapy would not be an option.
5. I understand there are potential risks involved with any type of psychotherapy, and that despite my efforts and the efforts of my counselor, my condition may not improve. 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. If I am experiencing an emergency situation, I understand that I should call 911 or proceed to the nearest hospital emergency room for help. If I am experiencing suicidal thoughts, I understand that I can call the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) for 24-hour crisis support.
7. I understand that I am responsible for (1) providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions, (2) the information security on my computer, and (3) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy sessions.
8. I understand that I have the right to access my medical information and copies of medical records in accordance with HIPPA privacy rules and applicable state law.
9. I understand that co-pays or payments for services will be made prior to the session by calling the office at 334-358-2455 and providing the necessary information to charge my credit/debit card. I also understand I have the option to mail a check to 1820 Glynwood Drive, Ste. B, Prattville, AL 36066

Having understood the entirety of the above listed information, I hereby grant consent for teletherapy services with my provider at Ellis Counseling, LLC.

Client Name (Printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

I give consent for my credit/debit card to be charged for any co-pay or service amount for my teletherapy session(s). I understand a receipt will be mailed to my address if requested.

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Client Signature Date Signed

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Credit Card Number Expiration Date

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Street Address Associated with Card

\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Zip Code