Motivations Counseling
Hope Begins Here !

Telehealth Informed Consent

To better serve the needs of the community, healthcare services are now available by interactive video communications and/or by the electronic transmission of information. This process is referred to as "telehealth." Telehealth involves the use of electronic communications to enable physicians and other healthcare professionals ("Treatment Providers") at different locations to share individual client clinical information for the purpose of improving client care. Treatment Providers may include, but are not limited to, counselors and marriage and family therapists. The information may be used for healthcare delivery, diagnosis, treatment, transfer of clinical data, therapy, consultation, follow-up and/or education, and may include client clinical records and live two-way audio and video. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of client identification and information. It is important that you understand and agree to the following statements.

Expected Benefits:

1. Improved access to healthcare by enabling a client to remain at a remote site while consulting with Treatment Provider.
2. More efficient healthcare evaluation and management.
3. Obtaining the expertise of a distant specialist.

Possible Risks:

Although rare, there are potential risks associated with the use of telehealth. These risks include, but may not be limited to:

1. Information transmitted may not be sufficient (e.g. poor connection) to allow for appropriate clinical decision making by the Treatment Provider and consultant(s);
2. Delays in evaluation and treatment could occur due to technical deficiencies or failures;
3. The transmission of client's clinical information could be interrupted by unauthorized persons; and/or the electronic storage of my clinical information could be accessed by unauthorized persons; and
4. A lack of access to complete clinical records may result in judgment errors.

Necessity of In-Person Evaluation:

A variety of alternative methods of clinical care may be available. A client may request alternative methods of care to telehealth from Treatment Provider. Telehealth-based services and care may not be as complete as face-to-face services. There are potential risks and benefits associated with any form of treatment, and that despite client efforts and the efforts of Treatment Provider, a condition may not improve, and in some cases may even get worse. If it becomes clear that the telehealth modality is unable to provide adequate treatment, the Treatment Provider will make recommendations to the client for further care.

By signing this form, We understand the following:

1. We understand that the laws that protect privacy and the confidentiality of clinical information also apply to telehealth. We understand that the information disclosed by us during the course of treatment is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including but not limited to:

   a. information demonstrating a probability of imminent physical injury to myself or others;
   b. suspicion of abuse of a child, elder, or individual with a disability; and
   c. if my clinical records are subpoenaed by a judge.
2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.
4. I understand that in the event of an adverse reaction to the treatment, or in the event of an inability to communicate as a result of a technological or equipment failure, I shall seek follow-up care or assistance at the recommendation of my Treatment Provider.
5. I agree to provide verification of Texas residency and inform my Treatment Provider immediately of any changes to residency.
6. **For minors seeking treatment**: I agree to verify guardianship of minors seeking treatment by providing requested documentation. Additionally, I confirm that the minor seeking therapy is 15 years of age or older.
7. I agree to secure a non-public environment for the duration of my telehealth sessions, including, but not limited to the following criteria: quiet, well-lit, enclosed area with minimal distractions and headphones/earbuds available. I will ensure confidentiality of my sessions by attending in a private setting.

In case of life-threatening emergency, call 911 immediately.

Please notify your therapist for any concerns you may have regarding your care. An individual who wishes to file a complaint against a licensed therapist may write to:

Complaints Management and Investigative Section
P.O. Box 141369
Austin, Texas 78714-1369

or call 1-800-942-5540 to request the appropriate form or obtain more information. *This number is for complaints only.* Please direct routine calls and correspondence to the phone number and address on the "Contact Us" page.

Client Consent To The Use of Telehealth

I have read and understand the information provided above regarding telehealth and understand I have the opportunity to discuss it with my Treatment Provider. I hereby give my informed consent for the use of telehealth in my clinical care.

I hereby authorize Motivations Counseling PLLC and its employees, agents and independent contractors, to use telehealth in the course of my diagnosis and treatment.

______________________________ ______________________________

(Signature) (Date)

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(Signature) (Date)