860 Hebron Parkway Suite #1102 ■ Lewisville, TX 75057 ■ www.cluffcounseling.com

TELEHEALTH INFORMED CONSENT

This statement of understanding has been prepared to help explain policies and procedures related to electronic services or virtual visits provided by Cluff Counseling PLLC. As a client receiving psychological services through telehealth methods, you, the client, understand:

1. This service is provided by technology (including but not limited to video, phone, text, and email). There are benefits and limitations to this service. You will need access to, and familiarity with, the appropriate technology to participate in the service provided. Exchange of information will not be direct and any paperwork exchanged will likely be exchanged through electronic means or through postal delivery.

2. You may decline any telehealth services at any time without jeopardizing your access to future care, services, and benefits.

3. The same fee rates, including the late cancellation fee, will apply for telehealth, as apply for in-person therapy. Payment for sessions and late cancellations will be made using a HIPAA compliant platform called *Ivy Pay*. You will be able to pay using any credit, debit or HSA/FSA card. Ivy Pay will save your card and your card will be charged on the day of your next session.

4. These services rely on technology, which allows for greater convenience in service delivery. There are risks in transmitting information over the Internet that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties. While specific encryption measures have been taken to protect the information that will be communicated between you and me, the privacy and confidentiality of computer mediated communication cannot be 100% guaranteed.

5. These sessions shall not be recorded in any way unless agreed to in writing by mutual consent. I will maintain a record of our session in the same way I maintain records of in-person sessions in accordance with my policies.

6. Any family member or other individual that you would like to have present during the virtual visit must also sign this document. To ensure patient safety and privacy, please participate in the virtual visit from a private location. All individuals present for the virtual visit must be within view of the camera so the provider is aware of who is participating.

7. Virtual visits should not be used for emergency mental health needs. In case of an emergency, please follow the General and Telehealth Emergency Plan that you have completed with your therapist.

8. It is your responsibility to maintain privacy on the client end of communication. Insurance companies, those authorized by the client, and those permitted by law may also have access to records or communications.

9. The laws and professional standards that apply to in-person psychological services also apply to telehealth services. This document does not replace other agreements, contracts, or documentation of informed consent.

860 Hebron Parkway Suite #1102 ■ Lewisville, TX 75057 ■ www.cluffcounseling.com

I have read and understand the information provided above. I have discussed it with my therapist. All of my questions have been answered to my satisfaction. I hereby request and consent to telehealth services as a part of my treatment. I understand that this agreement is intended as a supplement to the general informed consent that we agreed to at the outset of our clinical work together and does not amend any of the terms of that agreement. I agree to abide by the terms of this agreement.

_____ _____

Client 1 Date

_____ _____

Client 2 Date

_____ _____

Therapist Date