Capitol Hill Consortium for Counseling & Consultation LLC
650 Pennsylvania Avenue SE, Suite 440, Washington, DC 20003
P | 202.544.5440 F | 202.544.3004

# Telehealth Informed Consent

Client Name: _____Clinician: _____

Telehealth allows my therapist to diagnose, consult, treat and educate using interactive audio-video communication. I hereby consent to participating in psychotherapy via audio-video communication (referred to as telehealth below).

## I UNDERSTAND I HAVE THE FOLLOWING RIGHTS UNDER THIS AGREEMENT:

I have a right to confidentiality with Telehealth under the same laws that protect the confidentiality of my medical information for in-person psychotherapy. Any information disclosed by me during the course of my therapy, therefore, is generally confidential.

There are, by law, exceptions to confidentiality, including mandatory reporting of child, elder, and dependent adult abuse and any threats of violence I may make towards a reasonably identifiable person. I also understand that if I am in such mental or emotional condition to be a danger to myself or others, my therapist has the right to break confidentiality to prevent the threatened danger. My clinician and I will establish an emergency plan and protocol for contact in between sessions. This will be established before the start of treatment, and I can request a copy of these protocols in writing. Further, I understand that the dissemination of any personally identifiable images or information from the Telehealth interaction to any other entities shall not occur without my written consent.

I further understand that there are risks unique and specific to Telehealth, including but not limited to, the possibility that our therapy sessions or other communication by my therapist to others regarding my treatment could be disrupted or distorted by technical failures or could be interrupted or could be accessed by unauthorized persons. In addition, I understand that Telehealth treatment is different from in-person therapy and that if my therapist believes I would be better served by another form of psychotherapeutic services, such as in-person treatment, it may be recommended that I come into the office for sessions.

CCCC clinicians use Zoom to conduct telehealth sessions, in addition to our electronic health records system, Valant. Clinicians do not download any client PHI (personal health information) onto their computers, and are trained and up-to-date in HIPAA compliance. All client records are stored in Valant and comply with the highest HIPAA standards. In order to use Zoom, CCCC must have an accurate email address for you on file. Please be sure to include that at the end of this form.

I am responsible and not my insurance company for co-payments, coinsurances, and deductibles. I am also responsible for services not covered or denied by my insurance company. It is recommended that I call my insurance company to confirm in writing that they will cover telehealth therapy. My clinician will inform me of the time and cost of the non-covered services and make arrangement

with me for payment. Costs for services not covered by insurance are my responsibility, including payments expected from my insurance carrier which have been denied. Payments not made at the time of service are subject to a 1.5% fee increase every 30 days of non-payment and will be sent to collections after 90 days unless a payment agreement is adhered to.

I have read and understand the information provided above. I have the right to discuss any of this information with my therapist and to have any questions I may have regarding my treatment answered to my satisfaction.

I understand that I can withdraw my consent to Telehealth communications by providing written notification to CCCC, LLC. My signature below indicates that I have read this Agreement and agree to its terms.

Email for Zoom:_____

Best phone number for billing purposes:_____

I can also leave a credit card number on file for billing purposes:

CREDIT CARD NUMBER: __ __ __ __--__ __ __ __--__ __ __ __-- __ __ __ __

EXP. DATE: __ __ / __ __ CVC:_____ ZIP CODE:_____

NAME ON CARD: _____ _____ _____
(FIRST) (M) (LAST)

_____ _____
Client Signature Date

_____ _____
Clinician Signature Date