Wellspring Center, PLLC
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Teletherapy Informed Consent Form

Definition of Services:

I hereby consent to engage in teletherapy with Alicia Lopes Chinlund, MA, LPA, LCMHC, NCC, CHSP-LPA. Teletherapy is a form of psychological service typically provided via secure internet technology, which can include consultation, treatment, and transfer of medical data, emails, telephone conversations and/or education using interactive audio, video, or data communications. I also understand that teletherapy involves the communication of my medical and mental health information, both orally and visually.

Client's Rights, Risks, and Responsibilities:

1. I, the client, need to be physically present in the state of North Carolina (there are exceptions for deployed military personnel.)
2. I, the client, have the right to withhold or withdraw consent at any time without affecting my access to face-to-face care or treatment in the future.
3. 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 or consultation is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, which are discussed in detail in the general Informed Consent form I received at the start of my treatment.
4. I understand there are risks and consequences from teletherapy, including, but not limited to, the possibility that the transmission of my information could be disrupted or distorted by technical failures, the transmission of my information could be interrupted by unauthorized persons, or the electronic storage of my medical information could be accessed by unauthorized persons.
5. In addition, I understand that teletherapy-based services and care may not be as complete as face-to-face services. I also understand that if Ms. Chinlund believes I would be better served by another form of therapeutic services, such as face-to-face therapy, I will be referred to a professional who can provide such services in my area.
6. I understand that I may benefit from teletherapy, but that results cannot be guaranteed or assured. I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my best efforts and the efforts of my psychologist, my condition may not improve and in some cases may even get worse.
7. I accept that teletherapy does not include emergency services. If I am experiencing an emergency situation, I understand that I should call 911 or go to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255) for free 24 hour hotline support. Clients who are actively at risk of harm to self or others are not suited for teletherapy services. If this is the case, or becomes the case in the future, Ms. Chinlund will recommend more appropriate services.
8. I understand that there is a risk of being overheard by anyone near me if I am not in a private room while participating in teletherapy. I am responsible for (1) providing the necessary communications equipment for my teletherapy sessions, (2) securing the information on my own devices, and (3) arranging a location with sufficient lighting and privacy, that is free from distractions or intrusions for my teletherapy session. It is the responsibility of Ms. Chinlund to do the same on her end.

9. I understand that the dissemination of Personally Identifiable Information and images from the teletherapy interaction to researchers or other entities shall not occur without my written consent.
10. I understand I have a right to access my medical information and copies of my medical records in accordance with North Carolina law.
11. I understand that appointments may be canceled up to 24 hours in advance of the scheduled appointment, and that cancellation of appointments less than 24 hours in advance, as well as missed appointments, may incur a "no-show" fee, which is not covered by insurance plans. This policy applies to teletherapy sessions as well as face-to-face sessions.
12. I understand that I will be financially responsible for this treatment and for any portion of fees or charges not reimbursed or covered by my health insurance. I know of no reasons not to undertake this teletherapy and I agree to participate voluntarily.

_____	_____
Print Name of Patient	Print Name of Legal Guardian if applicable
_____	_____
Signature of Patient or Legal Guardian	Date
_____	_____
Signature of Psychologist	Date