# Life Transitions Counseling

**9254 Mosby Street #B**
**Manassas, VA 20110**

## CONSENT FOR TELEHEALTH TREATMENT:

1. I authorize my therapist at Life Transitions Counseling to use Telehealth services for our therapy sessions. Telehealth is the delivery of behavioral health services using interactive technologies (use of audio, video or other electronic communications) between a practitioner and a client who are not in the same physical location.
2. Electronic systems used are HIPAA-compliant and will incorporate network and software security protocols to protect the privacy and security of health information and imaging data. This system will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption. I understand that Telehealth is performed over a secure communication system that is almost impossible for anyone else to access, but because there is still a possibility of a breach, I accept the very rare risk that this could affect confidentiality.
3. I understand that I will need to access, and familiarize myself with this technology, in order to use the Telehealth. There is a possibility that the technology may fail during a teletherapy session, and that as a result, there may be an interruption; a need to continue by phone; or a need to reschedule.
4. I have been made aware of the benefits of Telehealth by my therapist, such as: improved communication capabilities during times when in-office sessions are not available; continuity of care; an out-of-office location of my choosing; and reduction of lost work time. I understand and recognize that there are also inherent risks in using Telehealth technology that may include: disruption of service due to technical difficulties; breaches of confidentiality; or theft of personal information,
5. Your insurance will be billed for the Telehealth session. While most plans cover this platform, there is always a chance that services may be denied. If that occurs, you will be responsible for any incurred charges/fees and will accept all financial responsibility as such.
6. The need for Telehealth services vs. in-person office sessions will continue to be evaluated and will be modified as needed. You retain the option to withdraw consent for virtual sessions at any time without affecting the right to future care or treatment.
7. You will abstain from alcohol and/or drug use before and during therapy all virtual sessions.
8. You are required to share your location during the virtual session with your therapist, in case an emergency should arise. In addition, you authorize that your emergency contact will be notified should an emergency arise.
9. In order to maintain confidentiality, I agree that I will not share my Telehealth appointment link with anyone unauthorized to attend the appointment. In addition, I will not allow another person in the same space during a virtual session nor will I record the session without consent.

By signing below, I affirm that I read the above guidelines in order to engage in Telehealth counseling treatment. In addition, I understand my rights and responsibilities as stated above.

____________________________________ ____________

Client Signature Date