File # _____
(Internal Use Only)

Universal Counseling, LLC

Teletherapy Client Consent Form

Client Name: _____ Phone number: _____

Email: _____ Provider Name: _____

Teletherapy is the delivery of behavioral health services using interactive audio and visual electronic systems, between a provider and client, to provide and support health care delivery, diagnosis, consultation, treatment, transfer of medical data and education.

The potential risks of teletherapy include, but are not limited to:

- A teletherapy session will not be as complete as face-to-face service.
- A lack of access to all the information that may be available in a face-to-face session, which can impact the judgment of the provider.
- Technical problems may occur (video quality, internet connection) that may affect the teletherapy session and affect the decision-making capability of the provider.
- Delays in evaluation/treatment may occur, due to deficiencies or failures of equipment.
- Universal Counseling utilizes software that meets the recommended standards to protect the privacy and security of the teletherapy sessions. However, the service cannot guarantee total protection against hacking or tapping into the teletherapy session by outsiders. This risk is small, but it does exist.

I understand that I have the following rights with respect to teletherapy:

- I have the right to withhold or withdraw consent at any time, without affecting my right to future care or treatment.
- 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 sessions is as confidential as possible with teletherapy services.
- I understand that there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of my provider, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons and/or the electronic storage of my medical information could be accessed by unauthorized persons.
- I understand that I may benefit from teletherapy, but that results cannot be guaranteed or assured.

Client's Responsibilities

- I will not record any teletherapy sessions without written consent from my provider. I understand that my provider will not record any of our teletherapy sessions without my written consent.
- I will inform my provider if any other person can hear or see any part of the session before the session begins. The provider will inform me of the same.
- I am responsible for the configuration of any electronic equipment used on my computer that is used for teletherapy. I understand that it is my responsibility to ensure the proper functioning of all electronic equipment before my session begins.

By signing this form, I <u>understand</u> the following:

- I must be a resident of the State of New Mexico to be eligible for teletherapy services from Universal Counseling.
- My provider will be meeting with me via teleconference equipment, in which we will be able to simultaneously see and hear each other.
- Teletherapy services are available on a case-by-case basis. Approval is at the discretion of the provider and/or clinical director. I understand that my provider determines whether the condition being diagnosed and/or treated is appropriate for teletherapy. This is intended to be an exception to face-to-face sessions, not the norm.
- The laws to protect privacy and confidentiality of medical information also apply to teletherapy.
- The information and client rights outlined in the Client Services Agreement (signed upon intake) continue to apply to me during my teletherapy appointments.

Client Consent To The Use of Teletherapy:

I hereby consent to engaging in teletherapy services with Universal Counseling as part of my psychiatric evaluation and treatment. I have read and understand the information provided above regarding teletherapy. This consent is effective as long as I am receiving psychiatric services from Universal Counseling, up to one year from date of consent on this form.

Client Signature	Date	Client Printed Name	
Client Authorized Representative	Date	Representative's Authority/Relationship	