



## TELEHEALTH CONSENT FORM

This document is provided in addition to the Chris Perry's Disclosure Statement and Treatment Agreement document in order to provide you with some specific information about your participation in telehealth counseling services.

### **Telehealth Policies**

At your request, and if it is clinically appropriate, we may make use of technology assisted telehealth tools such as telephone communications and internet enabled video and/or audio services if they are clinically appropriate.

- If you are located outside of the State of Washington, the counseling services I am allowed to provide to you may be limited or prohibited. If you are located outside of the State of Washington, we will discuss what services I may be able to provide to you.
- Telehealth services are not appropriate for all clients and all situations. If you or I determine that telehealth services are not appropriate for you, I will assist you in obtaining appropriate alternative services.
- Please do not access telehealth services in a location or manner that puts your safety at risk. This may include, but is not limited to, accessing telehealth while operating a motor vehicle. In such situations, I will ask you to disconnect from the session and rejoin as soon as you are able to do so safely.

### **Risks and Benefits**

It is important that you understand the following policies for telehealth services.

- Telehealth services may improve your access to counseling, may reduce your costs associated with counseling, may be necessary for continuity of care, and may support more effective use of in-person counseling.
- Successful use of telehealth services requires a reasonable level of access to computer hardware and software. If you do not have access to such resources, we can discuss available alternatives.
- At times it may become necessary for me to allow access to my computer hardware and software for purposes of system maintenance, repair, upgrades, or other similar purposes. In such cases, I will make reasonable efforts to protect your confidential information.
- Telehealth services may not be reimbursed by some insurance plans. In such cases, payment for telehealth services remains your sole responsibility.
- It is your responsibility to choose a secure location to interact with technology-assisted media and to be aware that without sufficient safeguards, third parties may overhear our communications or may gain access to the technology you are using. Some basic safeguards may include communicating only through a computer or device over which you maintain control, with a firewall and anti-virus software, password protection, and a secure private internet connection.

### **Alternative Modes of Communication**

In case of hardware, software or other system failure, you may reach me by phone or email to coordinate our continued work together.

Email: [chris@chrisperrytherapy.com](mailto:chris@chrisperrytherapy.com)

Phone: 206-888-0754

**Audio-Only Telehealth Billing**

Under Washington law, a healthcare provider may bill a client or the client’s insurance for audio-only telehealth sessions only with the prior consent of the client. If you would like to have the option to engage in audio-only telehealth services, you may initial below:

\_\_\_\_\_ (initial) if you consent to billing for audio-only telehealth services.

**Emergency Contact Information**

Please identify an Emergency Contact Person I may contact on your behalf in case of an emergency.

\_\_\_\_\_  
Emergency Contact

\_\_\_\_\_  
Phone Number

At the initiation of our therapeutic relationship I will ask you to provide me with the following contact information if you and I are in different geographic locations:

- Your local hospital emergency room phone number; and
- Your local crisis line phone number.

At the beginning of each session I will ask you to provide me to with following information if it has changed:

- Your physical location and address;
- A phone number I can use to contact you in case of technology failure or other loss of internet connection during our telehealth session;
- An email address I can use to contact you as an alternative if we cannot connect via phone.

**Acknowledgement and Consent**

By signing this document, you are attesting that you have received, read, fully understand and consent to the disclosures, terms, and conditions above, and that you are consenting to participation in telehealth counseling services provided by Chris Perry, MA, LMHC.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Client Name