Reflections Counseling of Denton

1306 N Locust St., Denton, Texas 76201
940-367-9887

TELEHEALTH/E-THERAPY CLIENT INFORMED CONSENT

I consent to receive telehealth/e-therapy and/or counseling/therapy sessions from Dennise Brosig who is a Licensed Professional Counselor- Associate under the supervision of Heather N. Smith, M.ED., LPC-Supervisor. I acknowledge that I am here voluntarily and that I may terminate treatment at any time. I realize that there is no guarantee of improvement in my condition. I acknowledge that any treatment will be a cooperative effort between me and Dennise Brosig.

I agree to actively participate in our telehealth/e-therapy and/or counseling/therapy sessions. I further acknowledge that the telehealth and/or counseling/therapy session is only one part of the process of change. Following through with the activities and trying the new behaviors agreed upon between sessions in most cases has a two-fold effect; increasing the opportunity for success and decreasing the number of sessions needed to begin to feel relief and see the desired change.

Risks and Benefits of Distance Counseling (telehealth/e-therapy)

Engaging in telehealth/e-therapy presents with both risks and benefits. Benefits include convenience and comfort for the client. Risks associated with telehealth/e-therapy may include possibility of technology failure, time zone differences, and ensuring further privacy. Your counselor will ensure privacy of counseling through encryption standards within their websites and/or technology-based communications that meet applicable legal requirements and will conduct counseling in a private setting. The technology used is through a website called **GoToMeeting** and uses encrypted point-to-point connections and is HIPAA-compliant and secure. Your counselor will provide you with information on how to appropriately log in. It is encouraged that the client also engage in telehealth/e-therapy in a location that is private in order to best maintain confidentiality. In order to ensure client safety, please provide the required information below:

Physical Address where you will be engaging in telehealth//e-therapy:
(Please note: If client is under 18 years of age, a parent or guardian must be present at the address provided)
Address: _____
_____
_____

Email to provide link for telehealth//e-therapy:

Email: _____

In case of an emergency (for example: if you feel that you are not safe or need additional therapeutic support), the client agrees for _____ to be contacted.

Phone number of emergency contact:

_____

Please Note: If your counselor determines that you need additional support that telehealth /teletherapy cannot provide, the client agrees to seek alternative, face-to-face counseling services. If the counselor is not able to provide face-to-face services, the counselor will support you in this transition in order to help secure appropriate therapeutic care.

Contact: Your counselor is not an emergency contact and contact outside of session time in any form will be limited to scheduling purposes only.

The following are the basic rights of individuals participating in telehealth/e-therapy and/or counseling/therapy:

- The right to be informed of the various steps and activities involved in receiving services
- The right to confidentiality under federal and state laws
- The right to humane care and protection from harm, abuse and neglect
- The right to make an informed decision regarding whether to accept or reject treatment
- The right to contact and consult with and select practitioners of my choice and at my expense

I understand that confidentiality of records or other information collected about me will be held or released in accordance with state laws regarding confidentiality of such records and information. I understand that the confidentiality of my record may be breached under the following circumstances:

1. If I sign a waiver requesting release of information.
2. If a court orders the release of my records.
3. If a mental status or competency should arise in a legal proceeding.
4. If Counselor should become unavailable due to serious illness or death. This would only be for the purpose of finding client contact information.

This form is supplemental to the initial paperwork overviewed and signed at intake

I have read and understood the above client informed consent and limits of confidentiality for counseling

_____ _____

Client Signature (Client's Parent/Guardian if under 18) Date

_____ _____

Other Parent/Guardian if under 18 Date

_____ _____

Counselor Signature

Date