**TELEHEALTH INFORMED CONSENT FORM**

By signing below, I affirm that I consent to telehealth treatment with Ivory Howell, LPCC and understand, regarding telehealth:

1. I have the right to withhold or remove consent at any time without affecting my right to future care or treatment.
2. My therapist may ask me to provide verification of address and identity.
3. All appointments scheduled are based on Central Standard Time.
4. Telehealth therapy may include mental health evaluation, assessment, consultation, treatment planning, and therapy.
5. Telehealth will occur primarily through interactive audio, video, telephone and/or other audio/video communications.
6. I will need access to, and familiarity with, the appropriate technology in order to participate in the service provided. Specifically, I must be able to navigate to the provided link via an internet-capable device which has audio and video capability.
7. Telehealth-based services and care may not be as complete as in-person services. If my therapist believes I would be better served by other interventions, I will be referred to a mental health professional who can provide those services in my area.
8. Intake notes, progress notes, and other appropriate documentation will be completed by my therapist and stored in TherapyNotes, along with payment and insurance-related data.
9. The laws that protect the confidentiality of my personal information also apply to telehealth, and I may refer to the Ivory Howell Counseling, LLC Notice of Privacy Practices for more information regarding use and disclosure of my protected health information.
10. There are risks and consequences for telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of Ivory Howell, LPCC that the transmission of my personal information could be disrupted or distorted by technical failures and/or the transmission of my personal information could be interrupted by unauthorized persons. If there is an interruption in service due to technical difficulty, my therapist will call me to make a plan to resolve the issue or take other appropriate action.
11. The use of some audio/video systems are not 100% secure and may have issues with internet connectivity. All attempts to keep information confidential while using these systems will be made, but a guarantee of 100% confidentiality cannot be made with inherent issues with these communication systems. I have been advised that I am responsible for attending a telehealth therapy session in a private setting, using ear buds or headphones to maximize confidentiality.
12. I will receive telehealth services via the Doxy.me platform, which does not store protected health information. This service is HIPAA and HITECH compliant, and Ivory Howell Counseling, LLC has secured a Business Associate Agreement with this platform provider. Doxy.me uses 128-bit encryption for video and audio communication and 256-bit AES encryption keys on data stored at rest.
13. My financial obligations to Ivory Howell, LPCC for telehealth services are the same as outlined in her Outpatient Services Contract, and it is my responsibility to contact my insurance company to understand my benefits as related to telehealth services and the possible denial of payment for these services.
14. Certain situations, including emergencies and crises, are inappropriate for audio/video/computer-based psychotherapy services. I should immediately call 911 or go to the nearest hospital or crisis facility if I am having thoughts about hurting or harming myself or others, having uncontrolled psychotic symptoms, or experiencing a life-threating situation.
15. If an emergency occurs during a telehealth session, I understand that my therapist may call 911, my emergency contact on file, or any other appropriate party. Additionally, I agree that if I am accessing my telehealth therapy session from any location other than the home address on file with my therapist, that I will inform my therapist before the session begins so that appropriate safety measures may be taken in the event of an emergency.

Printed name of client/parent/guardian Relationship (If applicable)

Signature of client/parent/guardian Date