Another Road Counseling llc
Teletherapy Informed Consent Form

I understand that my therapists video conferencing software is secure and HIPAA-compliant and they will do everything to ensure the security.

I will ensure that I am in a private location that allows me to have the same level of concentration and openness I show in the in-person sessions. If another person is present or enters the room, I will notify my therapist immediately.

I understand that while many insurance providers are approving these practices and are covering them in much the same way they would cover my in-office or face to face sessions, my therapist cannot guarantee that all insurances will cover all of these alternative services. My therapist has encouraged to call and find out my benefits. If telehealth services that I engage with are not covered by insurance, I acknowledge my therapist will have to bill me directly for those services.

The laws that protect the confidentiality of my medical information also apply to teletherapy. Unless we explicitly agree otherwise, our teletherapy exchange is confidential. I will not include others in the session or have others in the room unless agreed upon.

I accept that teletherapy does not provide emergency services. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help.

In the event our teletherapy is not in my best interests, my therapist will explain that to me and suggest some alternative options better suited to my needs.

I understand there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of my therapist, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons. I am responsible for information security on my computer.

I have read, understand, and agree to the information above.

_______________________________________ ____________________________________ ______
Client's Signature Client's Printed Name Date

If service is for a minor child, Print Client's name here ____

_______________________________________ ____________________________________ ______
Parent's Signature Parent's Printed Name Date

_______________________________________ Abigail DuPree LMSW_________________ ______
Therapist's Signature Therapist's Name Date