Empower
Counseling
Services, LLC

INFORMED CONSENT FOR TELEHEALTH

Telehealth/Tele counseling refers to diagnosis, consultation, client education and therapy delivered via electronic technology. This allows Empower Counseling Services to connect with clients using interactive video/audio communication. The telehealth platform used by Empower Counseling Services is Doxy.me. This is a HIPPA approved platform. One benefit of telehealth is that the client and clinician can engage in services without physically being in the same location. The client can be seen in different locations as long as those locations are within the state of SC.

Technology related Issues:

I understand that I will need to download an application/software and ensure good broadband Internet connection or a smart phone device with solid cellular connection for these services. I am solely responsible for any cost to obtain necessary equipment, accessories, or software to take part in telehealth services.
I understand that in the case of technology failure, I will attempt to re-establish connection with my therapist within my allotted appointment time. If I am unable to establish the connection, I will contact Empower Counseling Services to reschedule my appointment or to coordinate alternative methods of treatment.

Risks to Confidentiality:

I am expected to participate in my telehealth sessions from a safe, confidential location that will ensure privacy and minimize noise and other distractions. I will provide my location at each session, to include the address of my physical location, and I will announce any/all other individuals whom are present or within listening distance of my session. I further understand that my sessions may be deemed inappropriate to continue by the therapist due to any distractions or issues with confidentiality that are present.

I understand the risks unique and specific to Telehealth services, despite reasonable efforts by Empower Counseling Services, which may include potential therapy sessions an communications becoming distorted, disrupted by technology failures, or sessions becoming accessible to unauthorized persons.

Access to Services:

I understand telehealth counseling will not be provided to me if I am outside the state of SC. The exception to this is if I am out of state for a brief period of time, but reside in SC.

I understand scheduling appointments is based on the working hours of my therapist. Telehealth is considered outpatient services and is not intended as a substitute for emergency or crisis services. Whenever possible crisis appointments will be held in the office of Empower Counseling Services.

I understand that prior to discharge or termination of services for telehealth, I will comply with a final telehealth session with my therapist.

Fees:

The same fee rates will apply for telehealth as for in-person counseling sessions. The same late cancellation fees and no-show fees will apply. While some insurances and EAPs cover telehealth, this is not guaranteed. If your third-party provider does not cover telehealth, then you will be responsible for the full session fee. Please contact your insurance company prior to engaging in telehealth sessions to determine if these sessions will be covered.

Crisis Management Plan:

Furthermore, I understand if deemed necessary, my therapist may request a Welfare Check to be completed by local authorities and/or 911. Lastly, my therapist may also make recommendations for alternative treatment or refer me for a next available crisis appointment with Empower Counseling Services.

I understand that in the event of an emergency/crisis, or if the therapist is unable to clearly determine factors to ensure my own safety or that of someone else in the middle of my session, my therapist has the right to contact the following individual for assistance.

Personal Contact______________________________
Phone Number________________________________

I, ____________________________________, (name of client) consent to participate in telehealth services at Empower Counseling Services and agree to the following policies. I have discussed the policies with my therapist and have had the opportunity to ask any questions I have in regard to telehealth counseling prior to participation.

_______________________________ _______________

Client Signature Date

________________________________ _______________

Therapist Date