

# **ANDREA FORLINA, LCSW, RPT-S, EPT/S**

## **Healing Through Play: Counseling Services for Children, PLLC**

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### **TELETHERAPY INFORMED CONSENT POLICY**

I understand that “teletherapy” includes consultation, treatment, transfer of medical data, emails, telephone conversations and education using interactive audio, video, or data communications. I understand that teletherapy also involves the communication of my medical/mental information, both orally and visually.

I understand that I have the following rights with respect to teletherapy:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
2. Unless explicitly agreed otherwise, the teletherapy exchange is confidential. Any personal information I choose to share will be held in the strictest confidence. The laws that protect the confidentiality of my medical information also apply to teletherapy. Just as with face-to-face clients, the clinician will not release your information to anyone without your prior approval, or required to do so by law. In Colorado, mental health providers are required to notify authorities if they become convinced a client is about to physically harm someone or themselves; or if they are abusing, or about to abuse, children, the elderly, or the disabled.
3. I understand that this teletherapy occurs in the state of Colorado (USA), and is governed by the laws of that state. In a manner of speaking, you use modality to visit the clinician in his/her Colorado office.
4. I understand that there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of the clinician, 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.
5. In addition, I understand that teletherapy based services and care may not be as complete as face- to-face services. I also understand that if the clinician believes I would be better served by another form of therapeutic services (e.g. face-to-face services) I will be referred to a professional who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not be improve, and in some cases may even get worse
6. I understand that I may benefit from teletherapy, but that results cannot be guaranteed or assured.
7. I accept that teletherapy does not provide emergency services. During our first session, Andrea Forlina, LCSW and I will discuss an emergency response plan. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can

call the National Suicide Prevention Lifeline at 1.800. 273.TALK (8255) for free 24-hour hotline support.

8. I understand that I am responsible for the following: (a) providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions, (b) the information security on my computer, and (c) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session, (d) If I decide to keep copies of emails or communication on my computer, it is up to me to keep that information secure.

9. I understand that while email may be used to communicate with Andrea Forlina, LCSW, confidentiality of emails cannot be guaranteed.

10. I understand that I have a right to access my medical information and copies of medical records in accordance with HIPAA privacy rules and applicable state law.

By signing below, I acknowledge that I have read, understood, and agree to the information provided above.

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Client's Name

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Parent/Guardian's Signature

Date

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Parent/Guardian's Signature

Date

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Therapist's Signature

Date