

ALMA THERAPY
JANETTE S. CORDERO, LCSW-S
p: 512.522.2067
f: 512.201.2991



CONSENT FOR TELEHEALTH THERAPY

Telehealth therapy is the practice of delivering clinical health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations.

If you wish to engage in telehealth as part of our psychotherapy, please review and sign to consent to the following:

All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law. The privacy laws that protect the confidentiality of your protected health information (PHI) also apply to telehealth therapy unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; raise mental/emotional health as an issue in a legal proceeding). If you are having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telehealth therapy services are not appropriate and a higher level of care is required.

There are risks, benefits, and consequences associated with telehealth therapy, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.

During a telehealth therapy session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please call or text me at 512-522-2067 to discuss since we may have to re-schedule. There will be no recording of any of the online sessions by either party (client or therapist).

You are responsible for ensuring telehealth therapy services are covered by current insurance provider; if not covered at time of services, you will be billed at the rate of \$135/hour.

EMERGENCY PROTOCOLS

I may need to contact your emergency contact and/or appropriate authorities in case of an emergency. You will make me aware of your location, in case of an emergency, at the beginning of each session. You agree to provide me with an emergency contact person who I may reach out to on your behalf in a life-threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

In case of an emergency, your location is: _____

and an emergency contact person's name, address, phone:

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CONSENT TO USE TELEHEALTH FORMAT VIA *SimplePractice*

Telehealth by SimplePractice is the technology service we will use to conduct telehealth videoconferencing appointments. It is simple to use and there are no passwords required to log in. By signing this document, you acknowledge the following:

Telehealth by SimplePractice is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.

Though my provider and I may be in direct, virtual contact through the Telehealth Service, neither SimplePractice nor the Telehealth Service provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.

The Telehealth by SimplePractice Service facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.

I do not assume that my provider has access to any or all of the technical information in the Telehealth by SimplePractice Service – or that such information is current, accurate or up-to-date. I will not rely on my health care provider to have any of this information in the Telehealth by SimplePractice Service.

To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

I have read and understand the above information, and as the party using services and responsible for payment, agree to these conditions.

Client Signature

Date

Printed Name of Client