Turning Point Counseling Services
500 N. Washington St, Alexandria, VA 22314
4229 Lafayette Center Dr, Suite 1300, Chantilly, VA 20151

Informed Consent Addendum for Telehealth Services

Patient Name: _____

Address: _____ Phone:_____

Turning Point Counseling Services, hereafter referred to as TPCS, has presented to me the option of receiving counseling services through electronic technology, such as video conferencing, telehealth platforms, and other technologies that facilitate interaction between my counselor and me when we are not physically present in the same room at the same time. I understand that TPCS is able to provide telehealth, as permitted by law.

I understand that TPCS uses HIPAA-compliant electronic platforms. I also understand that TPCS is permitted by law to use third party vendors for services such as record keeping, billing, legal counsel, insurance, etc. I understand that I am responsible to provide my own secure internet connection (not public access wifi) and personal device that has a camera, microphone and speakers and that these are functional. I understand that it is my responsibility to know how to work my devices.

I am aware that while there may be benefits in engaging in telehealth services, it is not the same as in person therapy. I am aware of the advantages and disadvantages of counseling by electronic technology, including the inherent limitations of such counseling and the potential risks, including, but not limited to: technical failures, misunderstandings and miscommunications, interruption by unauthorized persons, unauthorized access to transmitted and/or stored confidential information, and decreased availability of a remote counselor in the event of a crisis. I acknowledge these risks and will not hold the TPCS or the therapist liable for any inconveniences or adverse outcomes.

I understand that I am responsible for my health and safety and for communicating my needs. If I am a danger to self or others, I will call 911 or go to the ER. I understand that if my therapist believes me to be a risk to myself or others, that they may call 911 or get me emergency medical help. If I can't get ahold of my therapist, I will call other support people and check other resources.

My emergency contact person is _____ and their contact

info is _____. My local hospital is _____.

Payment requirements that apply to in person sessions equally apply to therapy sessions conducted via telehealth methods. It is my responsibility to contact my insurance company to determine if telehealth services are reimbursable under my policy.

TPCS may not accept friend or contact requests from current clients on social media networking platforms (Facebook, Instagram, Twitter, LinkedIn, etc). The use of text messaging, emails and social media communication is not a secure form of communication. If I choose to communicate in these ways, I understand that I do so at my own risk. Urgent or sensitive communication should not be done over text, email, or social media. These means of communication are not monitored 24/7 by TPCS. Therapist will respond within a reasonable amount of time, unless it is on weekend or during holidays/vacations. I will discuss matters that are sensitive or safety related with my therapist in person or over the phone. Finally, each therapist is able to determine their own limits regarding the use of these forms of communication and can contract with client regarding the use of these telehealth services and electronic communication.

I understand that I must verify my identity to receive services via electronic technology. Identity must be verified during initial intake session with visible driver's license or valid state ID. I understand that I must also give the therapist the address of my physical location.

I understand that I am encouraged to take notes in session but I may not record counseling sessions. I agree to not allow others to listen in or see my visits without the agreement and knowledge of my therapist. I understand that my therapist will also not record sessions. I understand that my therapist may consult with colleagues, attorneys, and other professionals, as needed, about my situation but may not give identifying details about me, unless required by law. My therapist will let me know if this occurs.

It is the client's responsibility to ensure privacy at their location and if privacy is interrupted, immediately inform therapist. This may be communicated directly or via a previously established 'code word'. This code word can be used for safety reasons, interrupted privacy, and in communication.

I understand that all other policies, practices, agreements and paperwork that I have agreed to during in person therapy applies to telehealth visits. I understand that all previous applicable paperwork is still in force. I understand that this can change without warning, as needed. I understand that I, or my therapist, can stop a telehealth session at any time if it is deemed to not be appropriate to proceed. I understand that we are responsible for communicating this and must give notice and be reachable to address the reasons.

I understand that I must be located in VA or UT while receiving these services.

I understand the above and have communicated any concerns or questions.

I have carefully considered my options and am aware of the benefits and risks and I consent to receive counseling from TPCS through electronic technology.

Signature:_____Date:_____

Additional Client/ Parent/Guardian Signature: _____

Date: _____

07/21/20 Edition