H&L Psychological Services, LLC

Telehealth Services Informed Consent Acknowledgment

	Initial each statement below
	I understand H&L offers telehealth on a limited basis only.
	I understand the risks of telehealth and the need to be in a private location.
	I understand I must be in the state of Pennsylvania during the session unless special permission has been granted by another state's licensing board.
	I understand my therapist and I will decide which type of secure and HIPAA-compliant telehealth service to use.
	I understand I may need certain computer or cell phone equipment to use telehealth services and am solely responsible for any costs of equipment.
	I understand what to do if the session is interrupted or disconnected.
	I understand I am responsible for any fees not covered by insurance.

By signing below, I acknowledge that I have read, understood, and retained a copy of the **Telehealth Services Informed Consent Statement** (rev. 03/15/2020).

I understand that if I have questions about this policy, I can bring them up with my therapist.

I understand there may be times when this policy may need to be updated and I will be notified in writing of any policy changes and provided a copy of the updated policy.

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

(for minor clients only)

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Safety Plan for Telehealth Services

If, during the course of a telehealth session, it becomes clear that you are in a crisis situation that requires a higher level of care, it is important that your therapist be able to reach emergency contacts.

Please complete the names and telephone numbers of your local emergency contacts. Your emergency contact can be your local physician or a trusted family member, friend, or adviser who lives nearby. By including this information, you are giving your therapist permission to contact these individuals during a crisis.

_____

Local County Crisis Hotline Telephone Number

_____

Emergency Contact 1 Telephone Number

_____

Emergency Contact 2 Telephone Number

By signing below, I acknowledge that I have read, understood, and retained a copy of my **Safety Plan for Telehealth Services**. I give my therapist permission to contact the above individuals during a crisis situation.

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

(for minor clients only)