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TELEHEALTH CONSENT FOR MENTAL HEALTH SERVICES

The Client whose printed name and signature are written at the end of this **Telehealth Consent** form, and hereafter referred to as "Client," is the adult individual (18 years of age and older) consenting to, and agreeing with, the information provided in this document. **(Client Initials_____)**

The Client consents to engage in telehealth with *Pat Gossett, M.A., LPC*. The Client understands that "telehealth" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. The Client understands that the platform for such services is at the discretion of Pat Gossett, M.A., LPC, and will be delivered by via a platform that is intended to provide HIPAA compliant, non-public facing communication. (Non-public facing platforms are intended to allow only the individual and the person with whom the individual is communicating to see what is transmitted.) *Sessions are not able to take place if other individuals are present in Client's location (in the same room or are able to easily overhear Client's communications).*

The Client understands the following rights with respect to telehealth:

(1) The Client has the right to withhold or withdraw consent at any time without affecting the Client's right to future care or treatment, nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

(2) The Laws that protect the confidentiality of the Client's medical information also apply to telehealth. (Confidentiality inclusions and limitations are defined in the "Confidentiality and Informed Consent" document, also executed by the Client and included in Client's file.) As such, the Client understands that the information disclosed by Client during the course of therapy is generally confidential.

(3) The Client understands that there are risks and consequences from telehealth. These may include, but are not limited to, the possibility, despite reasonable efforts on the part of Pat Gossett, M.A., LPC, the transmission of Clients medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; the electronic storage of Client's medical information could be accessed by unauthorized persons and/or misunderstandings can more easily occur, especially when care is delivered in a telecommunications manner. In addition, the Client understands that telehealth-based services and care may not yield the same results nor be as complete as face-to-face services. The Client also understands that if Pat Gossett, M.A., LPC, believes the Client would be better served by another form of psychotherapeutic service (e.g., face-to-face service), the Client will be given referral resources to assist the Client in finding a psychotherapist in the Client's geographical area who can provide such services. Finally, the Client understands that there are potential risks and benefits associated with any form of psychotherapy, and that despite the Client's best efforts and the efforts of Pat Gossett, M.A>, LPC, the Client's condition may not improve and in some cases may even get worse.

(4) The Client understands that if emergency mental health services are needed, Client will contact their local emergency room and/or call 911.

The Client understands the following telehealth requirements:

(1) Telehealth sessions may only be engaged in when the Client is physically in Texas. The Client's location will be confirmed at the beginning of each telehealth session.

(2) The Client and Pat Gossett, M.A., LPC will engage in sessions only from a private location where either party will not be overheard or interrupted.

(3) Recording of sessions by the Client or Pat Gossett, M.A., LPC is not allowed.

(4) To engage in telehealth services, the Client must provide contact information for an emergency contact IN CLIENT'S LOCATION who can be contacted by Pat Gossett, M.A., LPC if Client is in crisis and Pat Gossett, M.A., LPC is unable to reach Client, or in the case of emergency during one of Client's telehealth sessions:

Emergency Contact Name: _____

Client's Relationship to Emergency Contact: _____

Emergency Contact's Address: _____

_____

Emergency Contact's Telephone Number: _____

Furthermore, Client endorses that the Emergency Contact individual listed above has previously been contacted by Client and has verbally agreed with Client to be listed as Client's Emergency Contact referral.

I, the Client, understand my rights and responsibilities as described in this document and request Pat Gossett, M.A., LPC, to provide telehealth counseling services to me.

* Client Signature	* Date
* Client Printed Name	
* Client Address	* Client Telephone Number (Primary)
* City, State, Zip Code	* Additional Client Telephone Number
* Patricia E. Gossett, M.A., LPC	* Date