**TELEHEALTH INFORMED CONSENT**

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**CONSENT FOR TELEHEALTH**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Client), hereby consent to engaging in telehealth with ***Lani Kish,* DBA Lani Kish Counseling PLLC** for therapy services. I understand 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. I understand that telehealth also involves the communication of my Protected Health Information, both orally and visually.

**TELEHEALTH RIGHTS**

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

I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment, nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

The Washington State and federal laws, including the Health Insurance Portability and Accountability Act (HIPAA), that protect the confidentiality of my medical information also apply to telehealth. As such, I understand that the information disclosed by me during my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim or myself; and situations in which I make my mental or emotional state an issue in legal proceedings. This information is detailed in the Notice of Privacy Practices that by singing below I acknowledge that I received and fully read the Notice of Privacy Practices. I understand that I have a right to access my medical information and copies of medical records in accordance with Washington State Law.

**EMERGENCY SERVICES PLAN**

I accept that telehealth does not provide emergency services. During our first session, my therapist and I will discuss an emergency response plan. If I am experiencing an emergency, 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 (800) 273-TALK (8255) for free 24-hour support.

**NO GUARANTEE OF RESULTS**

I understand that I may benefit from telehealth, but that results cannot be guaranteed or assured. Advantages of telehealth include but are not limited to: increased access to a broader range of providers, elimination of transportation concerns such as access and cost, easier access for clients whose concerns around trave/anxiety/interaction would have prevented their access to services, reduced risk for medically fragile clients, increased comfort, and familiarity for client in their own environments.

**TELEHEALTH ALTERNATIVES**

I understand that telehealth-based services and care may not be as complete as face-to-face services. I also understand that if my therapist believes I would be better served by another form of therapeutic services (e.g., face-to-face services) I will be referred to a therapist who can provide suck 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 therapist, my condition may not be improved, and in some cases, may event get worse.

**TELEHEALTH DISCLOSURES OF RISKS**

I understand that there are technological risks specific to telehealth, including but not limited to the possibility, despite reasonable efforts on the part of my therapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons. I understand that my risks of a privacy violation increases substantially when I enter information on a public access computer, use a computer that is on a shared network, allow a computer to ‘auto-remember’ usernames and passwords, or use my work computer for personal communications; and that I am solely responsible for securing my own electronic communication to protect my privacy of our interactions.

**MY TELEHEALTH RESPONSIBILITIES**

I understand that I am responsible for the following:

* Providing the necessary computer or telecommunications equipment for telehealth sessions.
* Personal security and/or protection on my computer
* Location with sufficient lighting and privacy that is free from distractions or intrusions
* Reliable and secure high-speed internet connection
* Backup forms of communications, (available and on record) if the internet connection fails

After electronically connecting, I will help my therapist complete a check-in to ascertain the immediate suitability of telehealth by verifying my name, location, whether I am in a situation conducive to a private, uninterrupted session, and my readiness to proceed.

***I have read, understand, and acknowledge agreement and understanding of the information provided in the Informed Consent.***

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**Patient Name Printed Date**

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**Patient Signature**