**COMPASS POINT COUNSELING LLC**

*Phone: (812)674-9999*

**TELETHERAPY CONSENT FORM**

*Definition of services:*

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby consent to engage in teletherapy with Compass Point Counseling LLC. Teletherapy is a form of psychological services provided via internet technology, which can include consultation, treatment, emails, and in special cases, phone conversations. I also understand that teletherapy involves the communication of my mental health information, both orally and visually.

Teletherapy has the same purpose as psychotherapy sessions conducted in person. However, due to the nature of the technology used, I understand that teletherapy may be experienced somewhat differently than face to face treatment sessions.

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

1. Normally, I would have to be a resident of the state of Indiana, but this restriction has been temporarily lifted in response to the current global pandemic. I understand this provision is subject to change and dependent upon the duration of the state of emergency.
2. I have the right to withdraw consent at any time. However, I if I choose to withdraw, I understand there are no face to face services provided at this time from Compass Point Counseling LLC due to the current state of emergency.
3. I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, which include, but are not limited to, danger to self or others, child or elderly abuse/neglect, or as may be required by a court of law.
4. I understand there are risks when participating in teletherapy. This includes, but is not limited to, the possibility that transmission of my information could be disrupted or distorted by technical failures, despite best efforts by my therapist to ensure high encryption and secure technology.
5. There is a risk that services could be disrupted or distorted by unforeseen technical problems.
6. I understand that I may benefit from teletherapy but that results cannot be guaranteed or assured. I understand 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 improve, and in some cases, may even worsen.
7. I accept that teletherapy does not provide emergency services. If I am experiencing an emergency situation, 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 1-800-273-8255 for free, 24-hour hotline support. Clients who are actively at risk of harm to self or others are not suitable for teletherapy services, and I understand that my therapist will recommend more appropriate services as needed.
8. I understand there is a risk of being overheard by anyone near me if I am not in a private room while participating in teletherapy. I am responsible for the following:

1) providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions; and

2) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session.

It is the responsibility of the therapist to do the same thing on his/her end.

1. I understand that dissemination of any personally identifiable images or information from my teletherapy interaction to research or other entities shall not occur without my written consent.

I have read, understand and agree to the information provided above regarding teletherapy:

Client signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_