



CONSENT TO TELEHEALTH SERVICES *with*
Alliance Child & Family Solutions (“ACFS”)
& the ALLIANCE CONNECT telehealth program

This consent form is incorporated into the Informed Consent to Treatment Form signed as part of initiating or continuing services with Alliance Child & Family Solutions (“ACFS”) or with any of the subsidiary programs of ACFS. The following information is provided to clients who are seeking Telehealth therapy or who may utilize this service at any point in the future. This document covers your rights, risks and benefits associated with receiving services via Telehealth.

Please know that ACFS has the utmost respect and positive regard for you and your well-being. We encourage you to keep communication open at all times to reduce any possible harm. Please use technology with discretion. Only communicate limited information such as appointment requests, cancellations or estimated times of arrival.

Telehealth Services Defined:

Telehealth Services means the remote delivering of psychotherapy health care services via technology-assisted media. This includes a wide array of clinical services and various forms of technology. The technology includes but is not limited to video, internet, a smartphone, tablet, PC desktop system or other electronic means. The delivery method must be secured by two-way encryption to be considered secure. Synchronous (at the same time) secure video chatting is the preferred method of service delivery as many insurances will not cover communication solely by phone, text, or e-mail.

Structure of Sessions:

ACFS offers face-to-face psychotherapy when appropriate and available. However, based on your ability to make in-person sessions and/or Therapist availability, you may receive virtual psychotherapy if the assessing Therapist and you determine in conjunction that Telehealth Services are appropriate for your treatment needs. Recommendation and ultimate determination will be made based on severity of symptoms, type of treatment, client access to secure online communication, and client ability to use the technology. If appropriate, you may engage in either face-to-face sessions, Telehealth or both. We will discuss what is best for you.

Training:

The LMFT Board requires 15 hours of required training to provide Telehealth services in the state of Texas by the LMFT board. Neither the LPC board nor the LCSW currently has a Telehealth training requirement. All Therapists, Master’s Level Clinicians under Supervision to be Fully Licensed, and/or Graduate Practicum Students will be held to the training requirement of their Supervising Board and Educational Degree.

Limitations of Telehealth Therapy Services:

While Telehealth Services offers several advantages such as convenience and flexibility, it is an alternative form of therapy or adjunct to therapy and thus may involve disadvantages and limitations. For example, there may be a disruption to the service (e.g. phone gets cut off or video drops). This can be frustrating and interrupt the normal flow of personal interaction. Primarily, there is a risk of misunderstanding one another when communication lacks visual or auditory cues. For example, if video quality is lacking for some reason, the Therapist might not see various details such as facial expressions. Or if audio quality is lacking, the Therapist might not hear differences in your tone of voice that would normally be more evident should you be seen in office.

Additionally, the therapy office decreases the likelihood of interruptions. However, there are ways to minimize interruptions and maximize privacy and effectiveness. Our Therapists will take every precaution to insure technologically secure and environmentally private psychotherapy sessions.

Client Responsibilities for Telehealth Therapy Services:

The virtual sessions can only be conducted while the client is within the state of Texas.

The virtual sessions must be conducted on a Wi-Fi connection for the best connections and to minimize disruption. We strongly suggest that you only communicate through a device that you know is safe and technologically secure (e.g. has a firewall, anti-virus software installed, is password protected, not accessing the internet through a public wireless network, etc.) Do not use “auto-remember” names and passwords.

Make sure you have checked your company’s policy before using a work computer for personal communication.



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As the client, you are responsible for finding a private, quiet location where the sessions may be conducted. **Sessions are not able to take place if other individuals are present in your location who have not previously signed a Release of Information or forms consenting to treatment as a group.** Consider using a “do not disturb” sign/note.

Identity and Location:

Your Therapist will be required to verify your identity and location at the start of each session. The Therapist will use a statement at the start of each session, such as: “Is this a good time?”. To confirm your availability, you will answer, “Yes, I am ready to start my session.” The Therapist will also verify your location at the start of each session after your identity has been confirmed.

In Case of Technology Failure:

It is possible that during a Telehealth session there could be a technological failure; difficulties with hardware, software, equipment, and/or services supplied by a 3rd party may result in service interruptions. If something occurs to prevent or disrupt any scheduled appointment due to technical complications and the session cannot be completed via online video conferencing, please call the therapist back at their direct extension to discuss other options to complete the visit, such as rescheduling the visit if there are problems with connectivity.

Social Media – Facebook, Twitter, LinkedIn, Instagram, Pinterest, Etc.

Please refrain from making contact with your treating therapist using social media or messaging systems. These methods have insufficient security, are not considered appropriate boundaries, nor are they closely monitored. We do not want to miss an important message from you.

Interactive Video, Electronic Medical Record, Secure Email for Documents:

ACFS currently utilizes Doxy.Me for interactive video. Doxy.Me keeps your information secure by ensuring no patient info is stored persistently, all data is encrypted using the AES cipher with 128-bit keys to encrypt audio/video, and HMAC-SHA1 to verify data integrity. Doxy.me adheres to HIPAA, PIPEDA, and GDPR data privacy requirements.

Consent for Telehealth Services Treatment:

By my signature below, I am indicating that I have read and understand all of the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment. I understand that I have the right to ask questions of the Therapist or Staff about the above information at any time. I also acknowledge by my signature below that:

- I voluntarily agree to receive online psychotherapy services or Telehealth for an assessment, continued care, treatment, or other services and authorize ACFS to provide such care, treatment or services as is considered necessary and advisable.
- I understand that there will be no recording of any of the online sessions and that all information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without my written permission, except where disclosure is required by law.
- **I agree to take full responsibility for the security of any communications or treatment on my own computer or electronic device and in my own physical location.** I understand I am solely responsible for maintaining the strict confidentiality of my user ID, password, and/or connectivity link. I shall not allow another person to use my user ID or connectivity link to access services. I also understand that I am responsible for using this technology in a secure and private location so that others cannot hear my conversations.
- I understand and agree that I will participate in the planning of my care, treatment or services and that I may withdraw consent for such care, treatment or services that I receive through ACFS at any time.
- I consent to the use of various forms of communication via technology including phone, e-mail, text, and video as is determined necessary for my care.

These signatures are signed and submitted as of today's date, _____

Name of Client (or Legal Guardian)

Signature of Client (or Legal Guardian)

***NOTE: The signatures on this form are considered valid and true regardless of whether hand signed or signed electronically through DrChrono OnPatient (computer or iPad), AdobeSign, or another approved electronic venue, that I am consenting to all of the above statements with my electronic signature, even if the signature does not appear on the exact lines above.**