THE HEIGHTS
COUNSELING AND WELLNESS

Telemedicine Informed Consent

I _____ [name of client] hereby consent to engaging in telemedicine at The Heights Counseling and Wellness, LLC as part of my psychotherapy. I understand that "telemedicine" includes the practice of healthcare delivery, assessment, diagnosis, consultation, treatment, transfer of medical data, and psychoeducation using interactive audio, video, or data communications.

Technology: I understand that I may need to download an application and/or software to use this platform. I also need to have a broadband Internet connection or a smart phone device with a good cellular connection at home or at the location deemed appropriate for services. I also understand that in case of technology failure, I may contact The Heights Counseling and Wellness, LLC via phone to coordinate alternative methods of treatment.

Financial Obligations: The fee for telemedicine appointments is $120 / 50 minutes. Fees associated with telemedicine appointments are payable by credit or debit card only. I agree to pay my session in full following each session by providing my credit card information. My card will be billed the same day as my scheduled telemedicine appointment. (Client Initial: _____)

Clients using insurance: I am responsible for contacting my insurance company, if applicable, to determine what my out-of-pockets costs may be. I authorize The Heights Counseling and Wellness, LLC to release any information to my insurance provider required for processing my claims. (Client Initial: _____)

Self-Pay clients: I am aware of the fees associated with telemedicine appointments and agree to pay at the time of my appointment. I understand that I am responsible for cancelled telemedicine appointments in accordance with The Heights Counseling and Wellness, LLC cancellation policy as documented by my signature on the Informed Consent. (Client Initial: _____)

Emergencies: Telemedicine appointments are considered outpatient services and not intended as a substitute for emergency or crisis services. Crisis or mental health emergencies should be directed to the local county crisis line or by dialing 911.

Video/Audio Recording: As a general practice The Heights Counseling and Wellness, LLC DOES NOT record Telemedicine sessions.

Confidentiality: The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, 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. See our Notice of Privacy Practices for a complete list. The most common **exceptions** include:

- CHILD, ELDER, OR DISABLED PERSON ABUSE. We are required by law to report any known or suspected cases.

- IF SOMEONE IS ABOUT TO KILL OR HARM SOMEONE ELSE we are required to do our best to warn the intended victim and notify the appropriate law enforcement authorities.
- IF A CLIENT INTENDS TO HARM HER/HIMSELF we will let others know as much as is needed to keep the client safe.
- HOSPITALIZATION FOR MENTAL ILLNESS may require that information be provided to the hospital so that they can provide you with the treatment you need.
- CERTAIN COMMUNICABLE DISEASES MAY HAVE TO BE REPORTED to the health department by law. Though the list does not include mental health conditions it is possible, although unlikely, that we might be the first to know of a medical condition that falls under the reporting requirements.
- IN THE CASE OF A MEDICAL EMERGENCY (for example, heart attack) we will release medical information to paramedics and/or the hospital that is necessary for treatment.
- COURTS MAY REQUEST OR REQUIRE RECORDS. Often subpoenas can be "quashed" or canceled. In most legal proceedings, you have the right to prevent me from providing any information about your treatment. In some proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it. Your clinician will tell you more about this if or when it becomes an issue.
- IF YOU ARE PART OF A LAWSUIT THAT INVOLVES YOUR MENTAL HEALTH CONDITION, we might be required to provide certain information to a court of law or judge.
- OTHER PROFESSIONALS - As a Licensed Graduate Professional Counselor, I am under the supervision of a Licensed Clinical Social Worker, and may consult with her regarding our sessions. I make every effort to avoid revealing the identity of my patient. The supervisor is also legally bound to keep the information confidential. If you don't object, I will not tell you about these consultations unless I feel that it is important to our work together.

The Heights Counseling and Wellness, LLC utilizes VSee, a Telemedicine platform that is HIPAA compliant to protect my privacy and confidentiality. HIPPA compliance is further explained in the Mental Health Informed Consent, which I have signed.

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

1. I have the right to withdraw my consent at any time.

2. I understand that there are risks and consequences associated with telemedicine including, but not limited to the possibility, despite reasonable efforts on the part of my counselor/therapist/clinical intern, that the transmission of my medical information could be disrupted or distorted by technical failures. In addition, I understand that telemedicine-based services and care may not be as complete as face-to-face services. I also understand that if my counselor/therapist/clinical intern believes I would be better served by another form of psychotherapeutic services (e.g. face-to-face services) I will be referred to a counselor/therapist who can provide such services in my geographic area.

3. I understand that I may benefit from telemedicine but that results cannot be guaranteed or assured.

4. I understand that The Heights Counseling and Wellness, LLC may not provide telemedicine services to me if I am outside of the District of Columbia, and I understand that I may access telemedicine services from The Heights Counseling and Wellness, LLC, from within the District of Columbia only.

5. I understand that I have a right to access my mental health information and copies of medical records in accordance with District of Columbia laws.

I have read and understand the information provided above. I have discussed it with my counselor/therapist/clinical intern, and all of my questions have been answered to my satisfaction. My signature below indicates my informed and willful consent to treatment using this platform.

_____ _____
Client Signature Date

_____ _____
Client Guardian's Signature Date

_____ _____
Provider's Name and Signature Date