Alicia McArthur, MA , LCMHC

Seeds Counseling & Collaboration, PLLC

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Informed Consent for Distance Counseling/Teletherapy/Telemedicine

I understand that Telemedicine (also referred to as e-therapy, teletherapy, telehealth, virtual teletherapy or video therapy) is the use of HIPAA compliant electronic information and communication technologies (including video and audio technology) by a mental health provider to deliver services to an individual when they are located at a site that is different than their provider. I understand that the Health Insurance Portability and Accountability Act (HIPAA) policies and laws that protect the privacy and confidentiality of my medical information also applies to Telemedicine. My rights to confidentiality with Telemedicine services are exactly the same as my rights for in-person therapy services.

There are also limits to confidentiality as dictated by law. Any information disclosed by me during the course of my therapy, therefore, is generally confidential with the exception of the following (for details on each, please refer to my professional disclosure statement):

1. Danger to yourself and others
2. Child abuse
3. Elder abuse
4. Litigation and legal proceedings
5. Insurance claims

Therapeutic treatment for mental health, both in person and through Telemedicine services, has been found to be effective in treating a wide range of clients. Individual results and responses to therapy may vary. By signing this form I also understand that results of any therapy, whether in person or through Telemedicine services, cannot be guaranteed.

I further understand that there are risks unique and specific to Telemedicine, including but not limited to, the possibility that our therapy sessions or other communication by my therapist to others regarding my treatment could be disrupted or distorted by technical failures, could be interrupted, or could be accessed by unauthorized persons. If a disruption or an emergency situation occurs, I understand that I can reach my therapist, Alicia McArthur, LCMHC at 704-989-9690. By signing this consent form I am indicating that I know how to contact my provider in case of disruption or emergency.

I understand that Telemedicine treatment for mental health is different from in-person therapy. I understand that if my therapist believes I would be better served by another form of therapeutic treatment or services, such as in-person treatment, I will be given that option or referred to another provider who can provide appropriate treatment options.

Additionally, I understand that the capture (including screenshots or photos of the therapy session), saving, or dissemination of any personally identifiable images or information from the Telemedicine interaction to any other entities shall not occur without my explicit written consent. Alicia McArthur, LCHMC, also agrees to under no circumstances take any personally identifiable images from the session or store any of these images on her own devices from Telemedicine sessions.

I understand that my Telemedicine appointment time is reserved exclusively for me. If I cannot attend my scheduled appointment, I will contact my therapist directly at least 24 hours before the session start time to reschedule. If I do not provide 24 hour notice for non-emergency reasons the usual late cancellation/no show fees apply (see the Professional Disclosure statement and Late cancellation/no show policy). Also, due to certain licensing requirements I agree to be physically in North Carolina each

session and to give my current physical address accurately at the beginning of each session. I also agree to tell my therapist at the beginning of each session if I am having any suicidal or homicidal thoughts.

I understand that the speed and quality of video must be quick enough to have a meaningful conversation, and that I am responsible for meeting and navigating the technology requirements on my end. I understand that Telemedicine appointments need to be conducted in a private and confidential space. I agree (unless otherwise agreed upon) to conduct my appointments in a private and secure room where I am the only one present. I will be prepared to do a "room scan" to ensure that I am the only one in the room.

I understand that I have the right to withhold or withdraw my consent to use Telemedicine services in the course of my care at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting Alicia McArthur, LCMHC, at 704-989-9690.

I have fully read, understand, and agree to comply with the information provided above. I understand I have the right to discuss any of this information with my therapist and to have any questions I may have regarding my treatment answered to my satisfaction.

Client name (printed): _____

Client signature: _____ Date: _____