



## DISCOVERY COUNSELING AND ASSESSMENT CENTER

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### TELEMEDICINE INFORMED CONSENT

This Informed Consent form is intended to inform you about Discovery Counseling's policies and procedures regarding **Telemedicine Services** and to ensure your agreement to these services. This consent form is **in addition** to our traditional consent form ("Practice Policies"), which must also be signed and agreed upon. Your signature on this form indicates that you, the client, are acknowledging that you understand and agree that your therapist will provide therapy to you according to this Telemedicine Informed Consent form. The content below must be read, discussed with your therapist at the initial consultation (and any time thereafter as needed) OR before the start of any Telemedicine Services, and agreed upon before any Telemedicine services can begin. Please ensure that each section is read and reviewed carefully. If you have any questions, please discuss them with your therapist before obtaining any Telemedicine and Telementalhealth services. Please print a copy of this policy for your records and this policy can be available at any time if requested.

I understand that Telemedicine (also referred to as e-therapy, teletherapy, telehealth, virtual therapy 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 any internet-based communication is not 100% guaranteed to be secure/confidential, even when using software that is represented as confidential and HIPAA-compliant. It is important to use a secure internet connection rather than a public/free Wi-Fi. I agree that ..... will be held harmless from any and all consequences if any outside party gains access to our confidential conversations.

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 following exceptions:

- Mandatory reporting of child, elder, and dependent adult abuse.

- Any threats of violence I may make towards a reasonably identifiable person.
- If I am in such mental or emotional condition to be a danger to myself or others, my therapist has the right to break confidentiality to prevent the threatened danger.
- Under court order or subpoena, the provider may be required to disclose information to person(s) as directed by the order or subpoena.
- If an investigation is being conducted by a licensing board or other government entity, information may be disclosed as directed by that board or entity.

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. In the event of technical problems, we may need to switch to a phone call or reschedule. By signing this consent form I am acknowledging that I know how to contact my provider in case of a 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 provided a referral to another therapist who can provide me with recommended services, such as in person therapy, if possible.

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. Discovery Counseling therapists also agree to under no circumstances take any personally identifiable images from the session or store any of these images on his/her own devices from Telemedicine sessions.

I also 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 48- hours before the session start time to reschedule. If I do not provide 48-hour notice a late cancellation fee will apply.

In accordance with our traditional informed consent, if you are unable to attend a scheduled appointment, you will be expected to pay a \$130 late cancellation fee unless you provide 48-hour advance notice. It is important to note that insurance companies do not provide reimbursement for cancelled sessions.

Similarly, if I am late to my scheduled session, I will receive my service for the remainder of my scheduled session time slot without refund.

Also, due to certain licensing requirements I agree to be physically in Georgia each session and to give my current physical address accurately at the beginning of each session. I agree to tell my therapist at the beginning of each session if I am having any suicidal or homicidal thoughts.

In accordance with the American Telemedicine Association (ATA) I agree to have Telemedicine sessions on a device that has a minimum bandwidth of 384 kilobits per second and a minimum live video display

resolution of 640 x 360 pixels at 30 frames per second. You can test your speed at <https://www.speedtest.net/>. These requirements mean that the speed and quality of video must be quick enough to have a meaningful conversation.

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 present in the room.

In the case that the client is a minor child, the child's parent or guardian agrees to help support their child in finding a confidential and private space. The parent also agrees to be either physically present at the location OR available via phone for the duration of the session and 15 minutes prior and after the scheduled session time. The parent must be willing and able to join the session at any time if requested.

I understand that I have the right to withhold or withdraw my consent to the use of 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 Discovery Counseling at 404-960-1282.

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.

My e-signature (or my actual signature) indicates that I have read this Telemedicine Informed Consent and agree to its terms. I hereby consent to participating in psychotherapy via Telemedicine Services with Discovery Counseling.

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_