#### **Courtney Zier Counseling**

Courtney Zier, PLLC

MA, LMHC

1121 E Thomas Street

Seattle, WA 98112

206.482.3991

#### **TELETHERAPY INFORMED CONSENT FORM**

I hereby consent to engaging in teletherapy with Courtney Zier, LMHC. I understand that “teletherapy” includes the practice of mental health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or telephone communications. I understand that teletherapy also involves the communication of my medical/mental information, both orally and visually, to Courtney Zier, LMHC via the teletherapy service, SimplePractice (a HIPAA compliant video platform service). I also understand that due to connection issues, the option to meet on FaceTime is an option given verbal consent at the time.

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

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
2. The laws that protect the confidentiality of my medical information also apply to teletherapy. 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, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.

I also understand that the dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent.

1. I understand that there are risks and consequences from teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons (e.g. hacking); and/or the electronic storage of my medical information could be accessed by unauthorized persons.

In addition, I understand that teletherapy based services and care may not be as complete as face-to-face services. I also understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my psychotherapist, my condition may not be improve, and in some cases may even get worse.

1. I understand that I may benefit from teletherapy, but that results cannot be guaranteed or assured.
2. I understand that I have a right to access my medical information and copies of medical records in accordance with Washington law.
3. I understand that, per the ethical guidelines of the state of Washington, teletherapy services can ONLY be provided to those residing in the state of Washington at the time of service.
4. Teletherapy will be billed at the same rate of individual therapy services.
5. Teletherapy is a temporary service that is being offered to all clients due to extreme circumstances as a precautionary measure. Once these circumstances abate, therapy sessions will return to in-person services as previously scheduled. Please contact your therapist directly if you have any questions.

**EMERGENCIES AND TECHNOLOGY**

Assessing and evaluating threats and other emergencies can be more difficult when conducting telepsychology than in traditional in-person therapy. If the session is interrupted for any reason, like the technological connection fails, and you are having an emergency, do not call me back; instead, call 911, or go to your nearest emergency room. Call me back after you have called or obtained emergency services.

If the session is interrupted and you are not having an emergency, disconnect from the session and I will wait two (2) minutes and then re-contact you via the telepsychology platform on which we agreed to conduct therapy. If you do not receive a call back within two (2) minutes, then call me on the phone number I provided you (206-482-3991).

If there is a technological failure and we are unable to resume the connection, you will only be charged the prorated amount of actual session time.

In case of emergency, my location is (address):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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My emergency contact person is (name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact person's phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand Courtney Zier, LMHC may contact my emergency person and/or appropriate authorities in case of an emergency.

**FEES**

Payment is due for both teletherapy and in-person sessions, at the time of your appointment. The initial session is a 90-minute session and is billed at $150.00. Acceptable forms of payment are cash, check, or, credit/debit card. If using a card, I use a secure, HIPAA-compliant credit card system called Ivy Pay, and will soon be switching to Simple Practices.

All missed, forgotten and late cancellations will be charged for the full amount of your scheduled appointment. A late cancellation is less than 24 hours prior to your appointment time.

I have read and understand the information provided above. I have discussed it with my psychotherapist, and all of my questions have been answered to my satisfaction.



Signature of Client Printed name of Client



Date Signature of Psychotherapist