



Teletherapy Consent Form

Please review this agreement carefully, as it sets forth the understanding between you (“Client”) and the Kellin, PLLC (“Agency”) regarding the services you have requested, and we will provide for you. If you have any questions, concerns or issues about the content of this Agreement please contact us for clarification before signing it.

THIS AGREEMENT made this _____ day of _____ (“Effective Date”) by and between the Agency and

Name of Client and/ or Responsible Person

Street Address	City	State	Zip Code
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Home Phone	Cell	Other
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Emergency Contact Name	Relationship	Phone No.
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Telehealth and Teletherapy is the use of electronic transmissions to treat the needs of a patient. In this case, we offer both video and audio forms of communication via the Internet and/or telephone. This means the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications, may occur from different locations geographically in order to assist with delivery of care when access to care may not be possible by face-to-face visits.

You understand that Teletherapy occurs in the state of North Carolina, and is governed by the laws of the state where the client resides. Teletherapy may also be governed by the laws of the state in which the providers are located at the time of service delivery, if that state is other than NC. All providers are licensed in the states in which you reside, as well as the state the provider may be located in at the time of a Teletherapy session.

While Teletherapy is an effective way to obtain assistance when geographic distance or scheduling conflicts prevent face to face care, in the event that Teletherapy is determined to not be in your best interests, your provider will explain that to you and suggest some alternative options better suited to your needs. In most cases this will likely include a recommendation for face-to-face psychiatric consultation or psychotherapy, or a referral to a facility or an agency that may provide a higher level of care. Teletherapy is not intended for emergency services, and if emergencies arise you will be required to seek face to face consultation and evaluation, and by signing this consent, you agree in advance to seek such care if you or your provider deem this necessary. In the event of an imminent emergency, clients should consult the nearest emergency room or psychiatric facility to provide emergent care.

You are responsible for information security on your computer. If you decide to keep copies of our emails or other communication on your computer, it’s up to you to keep that information secure. Unfortunately, we cannot guarantee the security of emails as they travel between computers. It is possible, though unlikely, to intercept emails in transit. If you are concerned about that possibility, please consider the option to encrypt our emails. Even if someone were to intercept an encrypted e-mail, they would not be able to read the encoded message.



Teletherapy via VSee* or Gsuite Meet is considered to be secure because it is reported by the manufacturer to be encrypted and therefore confidential so that it meets HIPAA acceptable privacy guidelines. Despite the manufacturer's representation, we do not independently certify that it meets encryption criteria for HIPAA compliance, and therefore you release Kellin from any liability in the event that teletherapy via VSee or Gsuite Meet is not secure and confidential as reported by the manufacturer.

Teletherapy may be received either from your chosen environment (e.g., home or work) or from a another location of your choice. You understand that you are responsible for (1) providing the necessary computer, telecommunications equipment and internet access for Teletherapy sessions; (2) the information security on your computer, and (3) arranging a location with sufficient lighting and privacy that is free from distractions and intrusions, and sufficient for privacy to protect your personal health information.

I understand that there are risks and consequences from Teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of the provider, 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; and/or the electronic storage of my medical information could be accessed by unauthorized persons. Other risks include Viruses, Trojans, and other involuntary intrusions have the ability to grab and release information you may desire to keep private. Furthermore, with Teletherapy, there is the risk of being overheard by anyone near you if you do not place yourself in a private area and protected from other's intrusion. You maintain sole responsibility for ensuring the privacy of your surroundings if participating in Teletherapy. Finally, you understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my provider's efforts, my condition may not improve, and in some rare cases may even get worse.

Payment for Teletherapy must be determined in advance with your provider or the practice. In NC, not all plans are fully insured or provide coverage for Teletherapy. In either event, a credit card must be kept on file for payment at the time of service, or payment must be made prior to the session. Some clients choose to pay in advance and leave credit balances on their account to cover future Teletherapy services when geographic distance precludes attendance on site. Please discuss coverage with your provider, and whether your insurance plan will cover the service.

Your signature and /or your representative's signature below indicate that you and/or your representative have read, understand and are in agreement with the terms and conditions of this agreement, including the following:

- You have read this agreement and agree to its terms
- You acknowledge that you have received the HIPAA Privacy Policy and Clients Rights and Responsibilities documents
- You have reviewed and agree to the Financial Agreement
- You have had the opportunity to ask any questions that you may have related to this agreement

Print Name of Client

Signature of Client

Date

Signature of Parent or Legal Guardian
(if client under 18-years-old)

Date

Witness

Date