ERJ COUNSELING

Elizabeth Reeder Johnson, MSW, LCSW

Child, Adolescent, Family & Couples Therapy

TELEHEALTH INFORMED CONSENT

I, _____, hereby consent to participate in Telehealth with, Elizabeth Reeder Johnson, MSW, LCSW, as part of my individual, group, family or couple's psychotherapy. I understand that Telehealth is the practice of delivering clinical mental health care services via technology assisted media or other electronic means between a practitioner and a client who are located in two different locations.

I understand the following with respect to Telehealth:

1. I understand that I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.
2. I understand that there are risks, benefits, and consequences associated with Telehealth, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies. All clients are encouraged to wear headphones and find a secure location to further protect their privacy.
3. I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.
4. I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to Telehealth unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding).
5. I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that Telehealth services are not appropriate, and a higher level of care is required.
6. I understand that during a Telehealth session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within two minutes, please call me at 214-293-5618 to discuss and continue the session via phone call if possible.
7. I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all my questions have been answered to my satisfaction.

Client's Name: _____

Client's Signature: _____ **Date:** _____

Parent/ Conservator's Signature if Client is a Minor _____ **Date:** _____