Chrysalis
CENTER FOR COUNSELING AND EATING DISORDER TREATMENT

3240 Burnt Mill Drive ▪ Suite 1 ▪ Wilmington, NC 28403 ▪ Tel: 910-790-9500 ▪ Fax: 910-796-8111

INFORMED CONSENT FOR TELETHERAPY

I, _____ (client name) hereby consent to engage in "tele-therapy" or "tele-health" with a provider from Chrysalis Center. I understand that tele-therapy may include, but is not limited to, mental health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications (i.e. phone, cellular phone, internet). I understand that teletherapy involves the communication of protected health information both orally and/or visually, between providers and clients.

- ❑ Tele-health will be provided at the discretion of my provider and the administration of Chrysalis Center, and may be dependent on diagnosis, duration of services, and the availability of appropriate technology. If your provider determines that tele-health is no longer appropriate, they may insist on in-person sessions or a hybrid of both types of service (also subject to state and federal regulations).
- ❑ There are potential benefits and risks in using tele-health, and it may be different than in person sessions. It may not be as comprehensive as face-to-face services. If the therapist believes that the client would be better served with another type of service or level of care, they may suggest alternatives.
- ❑ Clients may only use teletherapy services if both they and their provider are physically in the state of North Carolina.
- ❑ It is the client's responsibility to create an appropriate environment on their end of the transmission and to ensure, to the best of their ability, the confidentiality and integrity of their health information. The client assumes any risk to their private health information that is stored on their devices or in their account (such as email). No sessions should be recorded without permission from all parties. The client will need access to a smart-phone or webcam in a quiet, private space that is free of distractions and will not be interrupted during session.
- ❑ We agree to use the HIPAA compliant tele-health platform provided by Chrysalis. This program required access to email to join the confidential sessions. All parties will use a secure internet connection (no public or free wi-fi). In the event of a technical disruption, the session may migrate to a phone session, so the client must have a current phone number in the medical records system.
- ❑ The therapist will ensure that all standards that apply to in-office therapy will be consistent with teletherapy, including the confidentiality of information. Please refer to the Consent to Treatment and Privacy Practices for more information on those policies. There is a risk that, despite reasonable precautions on the part of Chrysalis Center, transmission of clients' health information could be distorted or disrupted by technological failures or accessed by unauthorized persons. The client understands that any policies on the part of technological providers (such as cellular carriers, meeting platforms, or messaging programs) may interfere or supersede health information confidentiality and assumes the risks of using these technologies.
- ❑ A safety plan will be implemented for every client receiving teletherapy in the event of an emergency. Clients should access 911 or the nearest hospital emergency room if needed. All clients will need to have at least one emergency contact on file to use tele-health.
- ❑ Teletherapy services may not be able to be covered by insurance or covered at the same rate; depending on your coverage, they may fall under the "self-pay" rate for services. The client is responsible for confirming this with their insurance company.

I have read and understood this document and will address any concerns or questions with my therapist, and/or the administrative team. Chrysalis Center reserves the right to change this agreement as necessary and in accordance with all applicable laws. Current copies of this agreement can be requested anytime and are available on our website.

Client/Representative Name (please print) _____

Client/Representative Signature _____ **Date** _____

I have addressed the client's/parent's/guardian's concerns and/or questions. The client appears fully competent to give informed consent.

Provider Signature _____ **Date** _____