Counseling Services
Teletherapy Consent Form

Definition of Services:
This agreement indicates consent for distance-oriented consultations or behavioral health sessions, otherwise known as teletherapy, which take place over a HIPPA compliant platform.
Teletherapy has the same purpose or intention as psychotherapy sessions or consultations that are conducted in the office of Counseling Services at Louisiana Tech University.

Client's Rights, Risks, and Responsibilities:
I understand that I have the following rights with respect to teletherapy:

1. I, the client, need to be located in the state of Louisiana at the time of counseling.
2. I, the client, have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
3. 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 or consultation is confidential, although all rules regarding mandated reporting and reporting harm to self or others remain the same as office sessions as per my professional ethical standards and legal protocol. Confidentiality will be held in the same regard to the identities of group members by all of those involved within the group.
4. I understand that there are risks and consequences of participating in teletherapy, including, but not limited to, the possibility, that despite best efforts to ensure high encryption and secure technology, our session could be disrupted or distorted by technical failures. If there is a loss of connection, I, the client, understand the therapist will initiate the call back, either to try again via Zoom or finish my session by phone.
5. I understand that there is a risk of being overheard by anyone near me if I am not in a private room while participating in teletherapy. I am responsible for (1) providing the necessary computer or telecommunications equipment and internet access for my teletherapy sessions, and (2) arranging a location with enough lighting and privacy that is free from distractions or intrusions for my teletherapy session. It is the responsibility of the counselor to do the same on his/her end.
6. I accept that teletherapy does not provide emergency services. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) for free 24 hour hotline support. **Clients who are actively at risk of harm to self or others are not suitable for teletherapy services**. If this is the case or becomes the case in future, the counselor will recommend more appropriate services.
7. I consent to giving my current location and the information of a Patient Safety Person in the event of disruption of service, or for emergency or administrative means. If my location changes at any time I will notify my therapist before our session begins.
   By signing this contract, I indicate my compliance with the above stated expectations.

I reserve the right to revoke my consent, in writing, at any time. This consent will be valid for 1 year following the date of signature.

Print Client Name: _____ **Client Signature:** _____

Student CWID # _____

Student Campus Email: _____

Current Address/Location: _____

Patient Support Person (PSP) Name and Phone Number: _____

Group you would like to join: _____

Date: _____/_____/_____