Coastal Haven Counseling, LLC

Informed Consent for TeleHealth / TeleTherapy Services

PATIENT NAME: _____

DATE CONSENTED: _____

TeleHealth /TeleTherapy involves the use of electronic communications to enable health care providers to continue to treat clients with mental health counseling at a distance.

Expected Benefits: Improved access to mental health care by enabling a patient to remain in his/her home or at a remote private setting while conducting counseling sessions with their therapist.

Possible Risks: As with any mental health procedure, there are potential risks associated with the use of telehealth/teletherapy. These risks include, but may not be limited to: In rare instances, security protocols could fail, causing a breach of privacy of personal private information. We utilize a HIPAA compliant platform for telehealth https://doxy.me to address this concern as best as possible.

Informed Consent for Telehealth: By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of mental health information also apply to TeleHealth/TeleTherapy, and that no information obtained in the use of TeleHealth/TeleTherapy which identifies me will be disclosed to other entities without my consent.

2. I understand that I have the right to withhold or withdraw my consent to the use of TeleHealth/TeleTherapy in the course of my care at any time, without affecting my right to future care or treatment.

3. I understand that I have the right to all information obtained in the course of a TeleHealth/TeleTherapy.

4. I understand that a variety of alternative methods of therapy care may be available to me, and that I may choose one or more of these at any time. My therapist has explained the alternatives to my satisfaction.

5. I understand that TeleHealth/TeleTherapy may involve electronic communication of my personal mental health information.

6. I understand that it is my option to inform my therapist of electronic interactions regarding my care that I may have with other healthcare providers.

7. I understand that I may expect the anticipated benefits from the use of TeleHealth/TeleTherapy in my care, but that no results can be guaranteed or assured.

Patient Consent To The Use of TeleHealth/TeleTherapy: I have read and understand the information provided above regarding TeleHealth/TeleTherapy, have discussed it with my therapist or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of TeleHealth/TeleTherapy in my mental health care. I hereby authorize my therapist at Coastal Haven Counseling, LLC to use TeleHealth/TeleTherapy in the course of my diagnosis and treatment. For questions or to reach us, our phone number is 843-945-0346 and email address is coastalhavencounseling@gmail.com.

Signature of Patient (or legal guardian): _____Date: _____

If authorized signer, relationship to patient: _____

Please note: You may request a copy of this document and we will furnish upon your request.