

Online Therapy Consent Form

Online Therapy and Limitations

I understand that online therapy includes the practice of health care delivery, diagnosis, consultation, treatment, and education using interactive audio and video communication. I understand that discussing my presenting concerns may cause discomfort as difficult issues are addressed and worked through. This is often a common experience of psychotherapy in general and I acknowledge no guarantees have been made to me as to the effect of treatment on my condition. I understand that phone and online sessions have limitations compared to in-person sessions, among those being the lack of "personal" face-to-face interaction, the lack of visual and audio cues in the therapy process, and the fact that most insurance companies will not cover this type of therapy. I understand online therapy is not appropriate if I am experiencing crisis or having suicidal or homicidal thoughts. Should crisis occur, I agree to call 911, go to the nearest emergency room, or contact a crisis hotline (e.g. 1-800-784-2433).

Procedures for technical difficulties or Internet disruptions

As a client of Life Enrichment Counseling, I understand that online therapy is technical in nature and that problems with the Internet may occur. If something beyond our control disrupts the connectivity of our session I will immediately try to video call the therapist again. If video call is repeatedly unsuccessful for 10 minutes, sessions will be:

- 1) completed via phone call to the therapist at **(317) 268-8070** or
- 2) refunded based on length of session prior to disruption (e.g. less than 10 minutes the session will be rescheduled at no cost, 15-30 minutes will result in half of the fee being refunded).

Appointment Payment

I agree to pay the agreed upon fee at least 2 days prior to my scheduled appointment. If payment is not made I understand the appointment will be cancelled. I understand that payment will be made via PayPal or prearranged agreement with the therapist (e.g. credit card or electronic check on file, which will be charged the day of the appointment).

Appointment Cancellations

If cancellation is needed, I understand that notice of at least 24 hours via phone call or email to the therapist is necessary in order to avoid any associated fees. Cancellations with less than 24 hours notice will be billed at \$30 per occurrence. Missing an appointment without prior notice will be billed at \$60 per occurrence. In addition, I understand that the accumulation of 3 late cancellations or missed appointments in any combination will result in referral to another counseling provider.

Termination of Services

During the intake and first few sessions, the therapist will assess if online therapy is of benefit to me and my needs. The therapist will use her best judgment to determine if online therapy is the best medium for providing me counseling services. If online therapy is deemed inappropriate, the therapist will provide me with a number of referrals in my area so face-to-face counseling can be pursued.

Confidentiality:

Because online therapy utilizes the Internet for the transmission of personal information I understand the therapist cannot guarantee confidentiality of the personal information I provide via this form of communication. However, any information that I provide to the therapist will subsequently remain confidential and will not be given to a third party unless I give specific permission to release the information, or the therapist is required to do so by law. The issue of confidentiality is further governed by both law and ethics. I understand that the therapist follows the law and professional regulations of the State of Indiana and the counseling treatment provided will be considered to take place in the State of Indiana.

By law I hold the privilege of confidentiality and the therapist will not release any information to anyone without my written permission, or a court order. There are some exceptions to my rights under the law. Examples include, but are not limited to, when the therapist has reasonable cause to believe that I am a danger to myself or another person. The therapist is also required by law to report any information about or reasonable suspicion of sexual, physical or emotional abuse of minors or elders to Child Protective Services or Adult Protective Services. I understand that if I have any concerns regarding confidentiality issues, I should speak with my therapist about these and other exceptions to the confidentiality privilege and her responsibility concerning them.

Harm to Self or Others

If there is an emergency during our work together where the therapist is concerned about my personal safety, the possibility of me injuring someone else or about my receiving proper psychiatric care, I understand the therapist will do whatever she can within the limits of the law to prevent me from injuring myself or others and to ensure that I receive the

proper medical care. For this purpose, the therapist may also contact law enforcement, hospital or an emergency contact whose name I have provided.

By signing this form I agree with the above.

Signature of Client

Date

Signature of Client

Date