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Telehealth Informed Consent Addendum

I _____ hereby consent to engage in telehealth with Dr. Donna Abbott as an adjunct for my psychotherapy treatment due to:

_____ scheduling difficulty/distance from office/frequent travel

_____ transition to a new therapist in another state

_____ relocation within Texas

_____ other addition to treatment plan

I understand that telehealth includes the practice of health care delivery, including mental health care delivery, diagnosis, consultation, treatment, transfer of medical date and education using interactive audio, video, and/or data communications.

I understand I have the following rights and responsibilities with respect to telehealth:

- 1) I have the right to withdraw consent for telehealth sessions at any time.
- 2) The laws that protect the confidentiality of my medical information also apply to telehealth. As such, I understand that the information disclosed by me during the course of my therapy is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality including, but not limited to: reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental health statements an issue in legal proceeding when decreed by a Judge.
- 3) I also understand that the dissemination of any personally identifiable images or information from the telehealth interaction to researchers or other entities shall not occur without my written consent. I also agree that I will not record sessions without express consent of Dr. Abbott
- 4) I understand that I am responsible for creating a safe and confidential space for myself during sessions and that this space is free of other people or that it would be difficult or

impossible for people outside the space to see or hear your interactions with your provider during the session.

- 5) I understand that there are risks and consequences from telehealth. These may include, but are not limited to, the possibility, despite reasonable efforts on the part of my psychotherapist that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; the electronic storage of my medical information could be accessed by unauthorized persons and/or misunderstandings can more easily occur, especially when care is delivered in an asynchronous manner (such as by telephone).

In addition, I understand that telehealth- based services and care may not yield the same results nor be as complete as face-to-face service. I also understand that if my psychotherapist believes I would be better served by another form of psychotherapeutic service (e.g., face-to-face service), I will be referred to a psychotherapist in my area who can provide such service. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my best efforts and the efforts of my psychotherapist, my condition may not improve and in some cases may even get worse. I have read the Informed Consent for psychotherapy provided by my provider in the intake package and acknowledge the same rules and regulations apply to telehealth.

- 6) I understand that I may benefit from telehealth, but results cannot be guaranteed or assured. The benefits of telehealth may include, but are not limited to: finding a greater ability to express thoughts and emotions; transportations and travel difficulties are avoided; time constraints are minimized; and there may be a greater opportunity to prepare in advance for therapy sessions.
- 7) I understand I have the right to access my medical information and copies of medical records in accordance with Texas law, that these services may not be covered by insurance and that if there is intentional misrepresentation, therapy will be terminated.
- 8) I agree to develop a plan for backup communication with Dr. Abbott in case of technology failures and a plan for responding to emergencies and mental health crises. In addition to those plans, your provider has the following policies regarding communications:

I agree that ongoing telehealth sessions are not appropriate if I am actively suicidal, have thoughts of harming others, am severely depressed or having psychotic episodes. I agree to inform Dr. Abbott of any suicidal thoughts, urges, substance use, and

hallucinations (voices/visions) or thoughts or fears of persecution/being controlled/watched, etc.

9) I understand laws in another state in which I am located may limit or not allow my time/sessions with Dr. Abbott. These limitations will be addressed by Dr. Abbott.

10) I understand that the same fees which apply to face-to-face psychotherapy which are outlined in my office policies apply to telehealth. Please be aware that not all insurance plans cover telehealth.

I have read and understand the information provided above, which has also been explained to me verbally. I have discussed the above with Dr. Abbott and my questions have been answered to my satisfaction.

Signature: _____

Date: _____