Kendra Witherspoon Kelly, LPC, NCC, MPH

Atlanta, GA 404.482.0009, contactme@trpllc.net

Telehealth Consent

Kendra Witherspoon Kelly, LPC, NCC, MPH, dba: The Resilience Project, LLC, Atlanta, GA

CONSENT FOR TELEHEALTH

Telehealth allows my therapist to diagnose, consult, treat and educate using phone, video or data communication regarding my treatment.

I hereby consent to participating in psychotherapy via telephone or the internet (hereinafter referred to as Telehealth) with the clinician listed below:

I understand I have the following rights under this agreement:

1. I have a right to confidentiality with Telehealth under the same laws that protect the confidentiality of my medical information for in-person psychotherapy. Any information disclosed by me during the course of my therapy, therefore, is generally confidential. There are, by law, exceptions to confidentiality, including mandatory reporting of child, elder, and dependent adult abuse and any threats of violence I may make towards a reasonably identifiable person.
2. I understand that the dissemination of any personally identifiable images or information from the Telehealth interaction to any other entities shall not occur without my written consent.
3. Further, I understand that if I am in such mental or emotional condition to be a danger to myself or others, my therapist has the right to break confidentiality to prevent the threatened danger.
4. I understand that while psychotherapeutic treatment of all kinds has been found to be effective in treating a wide range of mental disorders, personal and relational issues, there is no guarantee that all treatment of all clients will be effective dependent upon your current mental health needs. Thus, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.
5. I further understand that there are risks unique and specific to Telehealth, including but not limited to, the possibility that our therapy sessions or other communication by my therapist to others regarding my treatment could be disrupted or distorted by technical failures or could be interrupted or could be accessed by unauthorized persons.
6. In addition, I understand that Telehealth treatment is different from in-person therapy and that if my therapist believes I would be better served by another form of psychotherapeutic services, such as in-person treatment, I will be referred to a therapist in my geographic area that can provide such services.
7. I agree to provide a private (without anyone else in the room) and confidential space that is conducive for my session. I will ensure my video or phone line is clear and communicate if there are any issues in the connectivity. If use by phone, I may be asked to authenticate my identity and location using a variety of methods.
8. I understand that if a telehealth session is dropped, my therapist will attempt to reconnect and wait for me to do the same. If technology challenges continue, the session format can be requested to change from i.e. video to phone for remainder of time.

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9. If a period of 10 mins passes without you connecting for your session, the session will be terminated and fully charged.
10. I agree to provide emergency contact person and hospital preference info in the case of an emergency during the session and care is needed.
11. I have the right to discuss any of this information with my therapist and to have any questions I may have regarding my treatment answered to my satisfaction.
12. I understand that I can withdraw my consent to Telehealth communications by providing written notification to The Resilience Project, LLC

CONSENT TO USE THE TELEHEALTH BY SIMPLEPRACTICE SERVICE

Telehealth by SimplePractice is the technology service we will use to conduct telehealth videoconferencing appointments. It is simple to use and there are no passwords required to log in. By signing this document, I acknowledge:

1. Telehealth by SimplePractice is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
2. Though my provider and I may be in direct, virtual contact through the Telehealth Service, neither SimplePractice nor the Telehealth Service provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
3. The Telehealth by SimplePractice Service facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.
4. I do not assume that my provider has access to any or all of the technical information in the Telehealth by SimplePractice Service – or that such information is current, accurate or up-to-date. I will not rely on my health care provider to have any of this information in the Telehealth by SimplePractice Service.
5. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

BY CLICKING ON THE CHECKBOX BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

My signature below indicates that I have read this Agreement and agree to its terms.

Client name:

Kendra Witherspoon Kelly, LPC, NCC, MPH

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Client Signature:
Date: