jennifer ritter
COUNSELING

JENNIFER M. RITTER, LCPC
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Seen by Appointment Only

TELETHERAPY INFORMED CONSENT

Client Name: _____ DOB: _____

Email: _____ Contact Phone: _____

Individual clients and families are essential participants in health care and therefore it is critical to understand your rights and responsibilities while receiving care from Jennifer M. Ritter, LCPC. If you have any questions about this form, please ask.

If you are a parent/legally-authorized representative of a child, please read this agreement with the understanding that "I" and "me" means the child.

I _____, hereby consent to engage in teletherapy with Jennifer M. Ritter, LCPC. I understand that "teletherapy" includes consultation, treatment, transfer of medical data, emails, telephone conversations and education using interactive audio, video, or data communications. I understand that teletherapy also involves the communication of my medical/mental health, and court involved/legal information, both orally and visually.

I understand that I have the following rights with respect to teletherapy:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care and/or treatment.
2. The laws that protect the confidentiality of my medical/mental health, and court involved/legal information also apply to teletherapy. As such, I understand that the information disclosed by me during the course of my therapy or consultation is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, which are discussed in detail in the general Informed Consent and/or Court-Involved Therapy Agreement provided to you at the start of therapy.
3. I understand that there are risks and consequences from teletherapy, including but not limited to, the possibility, despite reasonable efforts on the part of Jennifer M. Ritter, LCPC, that: transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or electronic storage of my medical/mental health, and court involved/legal information could be accessed by unauthorized persons.
4. In addition, I understand that teletherapy based services and care may not be as complete as face-to-face services. I also understand that if Jennifer M. Ritter, LCPC, believes I would be better served by another form of therapeutic service (e.g. face-to-face services) this will be discussed and potentially a referral will be made to a professional who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my therapist, my condition and/or circumstances may not be improved, or in some cases, worsen.
5. I understand that I may benefit from teletherapy, but that results cannot be guaranteed or assured.
6. I accept that Jennifer M. Ritter, LCPC with use of 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. In addition, 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.

7. I understand that I am responsible for
    a. Providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions.
    b. The information security on my computer.
    c. Arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my teletherapy session.
8. I understand that while email may be used to communicate with my therapist, confidentiality of emails cannot be guaranteed.
9. I understand that I have a right to access medical/mental health information and copies of those records in accordance with HIPAA privacy rules and applicable state law, provided I make these requests in accordance with general office policies I received during my intake.
10. I understand that I have a right to access court-involved/court-ordered information and copies of those records in accordance with my court-order, HIPAA privacy rules and applicable state law, provided I make these requests in accordance with general office policies outlined in my Court-Involved Therapy agreement I received during my intake.
11. I understand that in the event we experience a technology failure during the course of our session, my therapist may not be able to reach me through technological means and will follow up via phone call or email to reschedule at the earliest available date/time. I also understand that if this interruption happens during the course of a "crisis" as deemed appropriate by clinical standards, my therapist may utilize my emergency response plan (including but not limited to -contact emergency contacts, parent/guardian, child/adult welfare, law enforcement, etc.) and/or engage local mental health services as outlined and explained in general informed consent paperwork and/or court-involved therapy agreement.
12. I understand that in the event of a mental health or other emergency, the "emergency contact" and/or "parent/guardian" may be notified and provided my physical location for the purpose of safety. I am also acknowledging that I understand, under the limits of confidentiality explained to me, should the need arise for my therapist to provide for an emergency mental health/welfare check, my therapist may notify my local law enforcement, child and/or adult welfare agency to provide these services.
13. I understand that clients, family members, and/or any third parties involved in telehealth therapeutic sessions are not permitted to take photographs of or audio/video record other clients and/or the therapist participating in the telehealth therapeutic session without prior written consent by Jennifer M. Ritter, LCPC. To the extent that Jennifer Ritter is aware of any inappropriate attempt to photograph and/or record audio and/or video of other clients and/or the therapist participating in the telehealth therapeutic session, Jennifer Ritter must and will take reasonable steps to ensure all parties are notified of this breach in agreement and/or implement appropriate sanctions determined by therapist. Note – violations of this agreement for court-ordered clients/families will likely result in termination of services and a detailed report provided to the court and attorneys detailing the reason(s) for termination.
14. I understand that all other Jennifer M. Ritter Counseling's policies apply to this therapeutic arrangement.
15. I understand that if I have any questions, or concerns about the information outlined in this informed consent I will discuss these in detail with my therapist. I also understand that should I feel at any point I do not understand and/or agree to the information provided above, I will withdraw or withhold consent either temporarily or permanently.

I have read, understand and agree to the information provided above.

Client Signature: _____ Date: _____

Parent/Guardian Signature (if applicable): _____ Date: _____