MOSAIC COUNSELING

Teletherapy Informed Consent

- I, _____, hereby consent to engage in teletherapy (i.e. online counseling) with my therapist through Mosaic Counseling Services. I understand that online counseling services include, but are not limited to, consultation, treatment, the transfer of medical data, emails, telephone conversations and education, using interactive audio, video, and/or data communications.

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

- I have the right to withhold or withdraw consent at any time without affecting my right to future care and/or treatment.

- The laws that protect the confidentiality of my medical information also apply to teletherapy. As such, I understand that the information disclosed by me during the course of my counseling is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, which are discussed in detail in Mosaic's Informed Consent, Policies, and Information document that was reviewed and signed during my Intake Session.

- If you are using insurance and your therapist is an in-network provider, Mosaic will bill your insurance company the contracted rate and you will be responsible for your portion. **Many individual insurance plans do not include teletherapy. It is solely your responsibility to understand your insurance company's policies regarding mental health coverage and teletherapy. You may call the number on the back of your insurance card to determine your benefits. If the insurance changes for any reason or insurance does not compensate for the complete portion, you will ultimately be responsible for the remaining costs of the contracted rate.** If your insurance changes, it is your responsibility to inform Mosaic Counseling Services.
  _____(initial)

- I understand that there are possible risks and consequences from utilizing online counseling services, including, but not limited to, the possibility, despite reasonable efforts on the part of my therapist, that: the transmission of medical information could be disrupted or distorted by technical failures; the transmission of medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

- In addition, I understand that online counseling services may not be as complete as face-to-face counseling services. I also understand that if my therapist believes that I would be better served by face-to-face counseling services, I will be given multiple referrals for therapists that can provide those services in my local area.

- I understand that there are potential risks and benefits associated with any form of counseling services, and that this is a standard part of the therapeutic process. While positive gains are expected and desired in counseling there is no certainty regarding outcomes. If a situation fails to improve or a situation deteriorates, my therapist can provide me with referrals to other professionals for consultation and/or treatment.

- I acknowledge that Mosaic Counseling Services does not provide emergency services. During the first session, my therapist will discuss an emergency response plan. If I am experiencing an emergency situation, I understand that I can call '911' or proceed to the nearest emergency room. If I am having suicidal ideation and/or making plans to harm myself, I can call the National Suicide Prevention Lifeline at (800) 273.8255 for free and 24 hours a day.

- I understand that I am responsible for providing the necessary computer, telecommunications equipment, and sufficient internet access for my online sessions. I am also responsible for the information security on my computer and arranging a location with sufficient lighting, privacy, and one relatively free of intrusions and distractions.

- I understand that I have a right to access my medical information and copies of medical records in accordance with HIPAA privacy rules and applicable state law.

Acknowledgment and Consent

By your signature below, you are indicating that you have read and understand this document, that any questions you have about this document were answered to your satisfaction, that you willingly consent to mental health treatment via teletherapy, and that you were offered a copy of this document.

_____ Printed Name of Client	_____ Signature of Client	_____ Date
_____ Printed Name of Parent/Guardian (If client is under 18)	_____ Signature of Parent/Guardian (If client is under 18)	_____ Date
_____ Printed Name of Parent/Guardian (If client is under 18)	_____ Signature of Parent/Guardian (If client is under 18)	_____ Date
_____ Printed Name of Therapist	_____ Signature of Therapist	_____ Date