Telemental Health Informed Consent Form

I,_____, hereby consent to engaging in teletherapy with Monica Hurt, LMFT, PLLC. I understand that "teletherapy" includes the practice of mental health care, delivery, diagnosis, consultation, treatment and education using interactive audio, video, or data communications of my medical/mental health information, both orally and visually, to Monica Hurt, LMFT, via the teletherapy service Zoom (a HIPPA compliant video platform service).

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 of treatment nor risking the loss or withdrawal of any therapy benefits to which I would otherwise be entitled.

(2) 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 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 toward an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.

(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 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 (e.g. hacking); and/or the electronic storage of my medical information could be accessed by unauthorized persons.

In addition, I understand that teletherapy based services and care may not be as complete as face-to-face services. I also understand that there are potential risks and benefits associated with any form of psychotherapy.

(4) I understand that I may benefit from teletherapy, but that results cannot be guaranteed or assured.

(5) I understand that I have a right to access my medical information and copies of medical records in accordance with KY law.

(6) I understand that, per the ethical guidelines of the State of KY, teletherapy services can only be provided to those residing in the state of KY at the time of service.

* Due to COVID-19 nationwide public health emergency the rules governing this restriction have been suspended and Monica Hurt, LMFT is able to provide teletherapy to most out of state residents. It is my responsibility to check my state's licensure requirements for telehealth.

(7) Teletherapy will be billed at the same rate of individual services.

(8) I have provided Monica Hurt, LMFT with the following information and I have given my permission to utilize my email address as a method to contact me.

* my home address
* my phone number
* my email address
* a secondary emergency contact (name/phone #)
* my local police department
* my local fire department

I have read and understood the information provided above. I have discussed any questions I have with my psychotherapist, and all of my questions have been answered to my satisfaction.

Client Signature_____Date_____