**Davis Counseling & Play Therapy Center, PLLC**

**Statement of Informed Consent for Telehealth (Online) Counseling**

**FOR CURRENT CLIENTS ONLY**

I, (printed name of client(s) or parent(s)/guardian) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

on behalf of (printed name of minor, if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

agree and give consent to receive telehealth (online) counseling and treatment by Suzanne Davis, LPC (Virginia), RPT-S™ (Registered Play Therapist-Supervisor™) (counselor) at Davis Counseling & Play Therapy Center, PLLC.

I understand that there are certain risks involved, such as being willing to disclose personal information and be open and honest with the counselor. I understand that I have entered into this therapeutic relationship voluntarily and may discontinue treatment at any time; however, there might be risks involved in discontinuing treatment early. The scope and nature of this treatment has been explained to me and I understand that there are no guarantees for treatment outcomes. I agree to hold harmless and indemnify the counselor from any damages, suits, claims, or liabilities arising from this therapeutic relationship.

**Confidentiality (initials)**

I understand that confidentiality will be maintained at all times within legal requirements of the Commonwealth of Virginia and by federal law as noted in the Health Insurance Portability and Accountability Act (HIPAA), and ethical guidelines according to the American Counseling Association Code of Ethics and the Association for Play Therapy Best Practices.

I understand that confidentiality will not be maintained if I threaten or give reason to believe that I will harm myself or others. If client(s) are involved in marital/couples counseling or family counseling, it is encouraged that each participant maintains a “no secrets” policy and that issues be addressed openly and honestly during the sessions.

**Confidentiality Limitations (initials)**

I understand that telehealth (online) counseling has some limitations in that the counselor cannot guarantee full confidentiality outside of the office. For example, who might be listening in or the security of internet connections on the client’s end. The counselor will use secure internet connections and take the necessary steps to make sure personal information is protected and remains confidential. The client is responsible for ensuring their own privacy on their end (e.g., use of a secure internet connection and meet in a place that is private and protected).

**Privacy of Information (HIPAA) \_(initials)**

I acknowledge that I have been given a copy of the counselor’s *Health Insurance Portability and Accountability Act (HIPAA) Patient Notification of Privacy Rights* which describes how records and information about my treatment will be handled.

**Credentials and Supervision \_(initials)**

The counselor is licensed by the Commonwealth of Virginia as a Licensed Professional Counselor through the Virginia Board of Counseling and is a Registered Play Therapist-Supervisor through the Association for Play Therapy. The credentials of the counselor have been explained to me.

I understand that the counselor will, on occasion, participate in clinical supervision and/or clinical consultation with other counseling professionals. Cases will be discussed with other counseling professionals solely for the purpose of gaining additional perspective, input and treatment direction. Confidentiality will be maintained in this supervision and/or consultation, and the names of clients will not be used or disclosed.

**Fees (initials)**

**I understand the fees involved in this treatment and that payment is expected at the time of the session**, unless other arrangements have been made and agreed upon with and by the counselor. I also understand that failure to pay the expected fee could terminate treatment and the settlement of any unpaid fees may be turned over to a collection agency. If the client does not show up for the session after payment, there are no refunds.

**Appointments (initials)**

**The length of individual counseling sessions and parent consultation sessions are 50-60 minutes, family sessions with the minor client present are 60-75 minutes, and marital/couples counseling sessions are 60-75 minutes.** I understand that appointments should be kept and that I should arrive on time for scheduled appointments. If the client is late for the session, the session time will be cut short based on the allotted time for the session. ***If the client is more than 15 minutes late for a scheduled appointment, the appointment will be considered as “no show” and will need to be rescheduled.* *“No shows” for appointments are subject to being charged a $50 no show/late cancellation fee.* Cancellations need to be made 24 hours prior to scheduled appointments, except in the case of family or medical emergencies.**

**By signing below, I have read, understand and agree to the terms and conditions in the Statement of Informed Consent for Telehealth (Online) Counseling:**

Signature of Client or Parent/Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By entering my initials below, I agree that the signature I have entered above will be the electronic representation of my signature and initials for all purposes when I use them on documents, including legally binding contracts – just the same as a pen-and-paper signature.

Initials: Date:

Counselor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_