Telehealth Authorization Form

I hereby consent to participate in telemental health with Stacey Laves-Khalifa MEd, LPC as part of my psychotherapy. I understand the following with respect to telemental health:

Telehealth allows my therapist to diagnose, consult, treat and educate using interactive audio, video or data communication regarding my treatment. I hereby consent to participating in psychotherapy via telephone or the internet

There are potential risks and benefits associated with telemental health, including but not limited to, disruption of transmission by technology failures, limits of confidentiality, and/or limited ability to respond to emergencies.

Client confidentiality and privacy laws still apply. 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.

There will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization and/or is required by law.

Client has to be residing in Texas when in session.

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. Thus, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.

If I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate.

There are some circumstances in which telemental health is not appropriate or good practice, and sessions may need to resume in-person.

I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

Please confirm with your insurance company that the telehealth sessions will be reimbursed; if they are not, you are responsible for full payment.

We agree to use the secure video conferencing platform for our virtual sessions, and your therapist will explain how to use it.

Phone sessions lack the benefits of the therapist to see the client and research has shown that clients in turn have a decreased attention span. In most circumstances phone counseling will not be offered.

It is important to be in a quiet, private space that is free of distractions. Although the video is secure, it is best not to be on public area or public Wi-Fi. It is also important to be on time and notify your therapist in advance as you would an in-person session.

In case of emergency, my contact person is:

Name: _____

Phone: _____

Relation to patient: _____

I have read the information provided above and discussed it with my therapist. I understand the information contained in this form and all of my questions have been answered to my satisfaction.

Client Name: _____

Client ID: _____

Phone Number: _____

Date: _____

Signature: _____

If Client is a minor please complete below

Parent/Guardian Name: _____

Date: _____

Signature: _____

By signing and sending back this form to therapist, you agree to the terms of this form and authorize your name as your signature.