VIRGINIA TECH
College of Liberal Arts and Human Sciences

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FAMILY THERAPY CENTER OF VIRGINIA TECH
Telehealth Therapy Agreement

Agreement to Treatment

I hereby give my permission to participate in telehealth services provided by the Family Therapy Center (FTC) of Virginia Tech. My telehealth services at the FTC involve using the telephone and/or a HIPAA-compliant audio-visual platform for therapy, testing, or diagnostic evaluation to treat me individually, or my couple and/or family relationships. Telehealth services permit me and/or my family members to have real-time communication with my therapist, from different physical locations outside of the FTC, as long as my therapist and I are both physically in Virginia at the time of telehealth service delivery.

I understand that the telehealth services are temporarily being offered to allow for the continuation of services during the COVID-19 outbreak. When deemed appropriate by staff at the FTC, I understand that I will resume face-to-face therapy sessions with my therapist and that telehealth services may no longer be available to me.

I understand that the FTC will not bill me for my initial telehealth sessions. I acknowledge that this fee waiver will be re-evaluated at regular intervals and that I will be notified, in advance, of any changes. Upon notification of billing options for telehealth services, or when I am able to receive face-to-face services at the FTC, I understand that I will agree upon a session fee and pay the agreed upon amount (as noted on the *FTC Client Payment Plan* that I and/or my significant other will electronically or physically sign after a discussion with my therapist).

I am aware that, at any time, I have the right to withhold or withdraw my consent to receive telehealth services, without affecting my right to future care or treatment. In such cases, I have the right to temporarily suspend my services, until I can resume face-to-face services at the FTC, or request a referral to another provider. I am further aware that, if my therapist believes I would be better served by another form of intervention (e.g., face-to-face services) or that telehealth services are not the best way to meet my needs, I will be referred to another provider.

Understanding of Telehealth Services

I understand that there are potential benefits to participating in telehealth sessions. Despite my efforts and the efforts of my therapist, I understand that therapy may sometimes lead to unanticipated emotional stress as well as relief and growth, and that the FTC does not guarantee any particular results or outcome from the therapy process, including telehealth services.

In order to receive telehealth services from the FTC, I understand that I am responsible for 1) providing the electronic device(s), such as a telephone or a computer with a webcam and/or audio capability, and the internet access necessary for my telehealth sessions, 2) maintaining the security of my electronic device(s), 3) arranging a location with sufficient privacy that is free from distractions or other intrusions and 4) maintaining a secure internet connection (instead of public/free Wi-Fi). I understand that my therapist will guide me in the use of the technology associated with our telehealth sessions.

I further understand that there are potential risks associated with participating in telehealth services. I understand that my therapist uses secure audio-visual transmission software to deliver telehealth services. However, it is still possible that my personal information could be obtained by an unauthorized third party. I agree that my therapist or I can discontinue any telehealth session if we believe that the audio/video connection or setting is not adequate to insure my confidentiality and privacy. I also understand that my therapist will stop any telehealth session immediately if an unauthorized party attempts to participate in any way.

Despite reasonable efforts on the part of my therapist, I understand that my telehealth sessions may be disrupted or distorted by technical failures or difficulties. If this occurs, my therapist will make a good faith effort to troubleshoot and/or restore contact using the telephone or the chat feature of the audio-visual platform. If contact cannot be restored relatively quickly (within 15 minutes or so), the telehealth session will be rescheduled.

I understand that my therapist will wait 15 minutes for me to join any scheduled telehealth session. After that time, I understand that my therapist will not necessarily be available, and I will need to contact my therapist through our agreed upon contact phone number (i.e., FTC therapist voicemail or Google Voice) to reschedule.

Agreement to Contact

While receiving telehealth services from the FTC, I understand that I will contact my therapist through the university voicemail system, unless I agree to communication via Google Voice. If I choose to use Google Voice at this time, I will inform my FTC therapist, who will note that I've given this permission in my clinical record. If I choose this option, I acknowledge that Google Voice is inherently insecure and could result in an unauthorized disclosure of my information. If at any time, I decide that I want to change how I communicate with my FTC therapist, I will notify my therapist immediately so that my therapist is able to document my new communication preferences.

I authorize my FTC therapist to contact me through Google Voice: ______ YES ______NO

All calls are generally returned within 24 hours, during weekdays. To facilitate communication with my therapist, I agree to maintain my phone in such a way that my therapist has the ability to leave me voicemail messages.

If I need to cancel or change my telehealth session, I agree to notify my therapist via either the therapist's direct FTC voicemail, or if I have agreed to have contact with the therapist via Google Voice, their Google Voice phone number, at least 24 hours in advance.

I understand that, depending on the type of telehealth platform I use, I will receive information about connecting to my telehealth sessions via an email from the FTC. I agree to supply my email address to the FTC for this purpose, and to receive communication about my sessions in this format. I understand that I am prohibited from communicating with my therapist via email for any other purpose and should never share confidential information through email. If need to communicate with my therapist, I will do so over the telephone, as described above.

I authorize contact with me via FTC administrator-approved email: ______ YES ______NO

If yes, please type your email address here: _________________________________

Agreement to Electronic Recording & Observation

Because the FTC is part of the doctoral program in marriage and family therapy at Virginia Tech, and is an educational facility, I agree to allow electronic recording and observation of my therapy sessions via a HIPAA compliant audio/visual platform for the purposes of clinical treatment and training. I understand that only FTC administrators, FTC staff, clinical supervisors, or authorized visiting mental health professionals will be allowed to view these recordings or to observe actual therapy sessions, and that they will treat any information they receive with strict confidentiality, except as noted below. I recognize that electronic recording of all sessions is a requirement of therapy, while observation will occur at the initiation of my therapist or my therapist's supervisor.

The electronic recordings of my therapy sessions will be stored on an encrypted, university-issued computer assigned solely to my FTC therapist for clinical use. My therapist will delete recordings of my therapy sessions at regular intervals, as instructed by FTC administrators.

I understand that photographing, audio, or video recording part or all of a telehealth session is prohibited and may result in termination of FTC services and referral to another agency.

Understanding of Confidentiality

I understand that the FTC maintains electronic medical records. These and other information concerning therapy will be kept in strict confidence by my therapist, FTC administrators and staff, or anyone otherwise affiliated with the FTC. Therapists and FTC staff may not give information about my therapy to others, including the fact that I, and/or my partner or family members are in treatment. These standards of confidentiality will be upheld, except in circumstances when disclosures are specifically required to by law (see below), and/or with my specific written consent. If I attend telehealth sessions with my partner or any other adult, then everyone attending the session(s) must agree in writing for records of our sessions together to be released to any third party.

Exceptions to Confidentiality

I understand the same limits to confidentiality that apply in face-to-face sessions also apply to telehealth sessions, and that my therapist or FTC staff may be legally or ethically required to divulge information without my permission. I understand that my therapist or FTC staff is required by professional ethics and law to report evidence or suspicion of child or adult abuse or neglect, with or without client consent, including any evidence or suspicions formed in the course of treatment. I further understand that my therapist and the FTC staff are required by professional ethics and law to report threats to physically harm others or myself that I, my partner(s), or family members may make. I also recognize that my therapist and FTC staff are legally obligated to break confidentiality when ordered by a court of law. Finally, if I develop COVID-19 or am experiencing COVID-19 symptoms, I understand that my therapist and the FTC staff may be legally required to report this information to the local health department.

Understanding that the FTC is Not an Emergency Service

I am aware that the FTC is not an emergency or 24-hour service. In an emergency, I will call the RAFT Crisis Hotline or 9-1-1, or will proceed to the nearest hospital emergency room for help.

Consent

By signing my name in the designated area(s) below, I certify that I have received the information contained in this document and have been given the opportunity to ask questions and have them answered. I fully understand and agree to participate in telehealth services offered by the FTC. My verbal consent will be documented in my clinical record by my therapist.

____

Client Signature (Adult -18 or older)/Date

____

Client Printed Name

____

Legal Guardian Signature/Date
(For any minor client; Mark "NA" if no minors)

____

Legal Guardian Printed Name
(For any minor client; Mark "NA" if no minors)

____

Printed name of EACH minor client; Mark "NA" if no minors

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FTC Staff/Therapist Signature/Date

____

FTC Staff/Therapist Printed Name

Updated 4/23/2020