Rachel Yost, LPCC-S, LICDC
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TELEHEALTH INFORMED CONSENT

This document explains the services I provide, your rights as a client, and information about participating in counseling via telehealth.

NATURE OF COUNSELING SERVICES

Counseling involves discussing personal, emotional, relational, or mental health concerns in order to support growth, insight, and symptom relief. The counseling process may include exploring difficult thoughts, feelings, and experiences. While many clients experience benefit, counseling may also involve discomfort as part of the change process. Results of counseling vary and cannot be guaranteed.

TELEHEALTH SERVICES

Telehealth involves providing counseling services through secure video conferencing technology rather than in person. By participating in telehealth services, you understand and agree that:

- Sessions will occur through a HIPAA-compliant video platform.
- You are responsible for ensuring you are in a private, quiet, and secure location during sessions.
- You should use a secure internet connection whenever possible.
- Technology interruptions (audio/video loss, disconnection) may occur, and we will attempt to reconnect or reschedule as appropriate.

BENEFITS AND RISKS OF TELEHEALTH

Telehealth may offer increased convenience, accessibility, and comfort. However, risks may include:

- Technical difficulties or service interruptions
- Reduced nonverbal communication compared to in-person therapy
- Potential breaches of privacy if you are not in a secure environment
- Limitations in responding to emergencies in real time

By consenting to telehealth, you accept these risks.

CONFIDENTIALITY

Your privacy is protected by law and governed by the Notice of Privacy Practices provided to you, which explains in detail how your health information may be used or disclosed. In addition to those protections, confidentiality may be legally limited in the following situations:

- Risk of serious harm to yourself or others
- Suspected abuse or neglect of a child, elderly person, or vulnerable adult
- Court orders or valid legal requirements

When possible, I will discuss any required disclosures with you before they are made.

EMERGENCY SITUATIONS

Telehealth is not appropriate for emergencies. If you are experiencing a mental health or medical emergency, call 911, go to the nearest emergency room, or contact a crisis resource such as 988 (Suicide & Crisis Lifeline). Because telehealth services are not appropriate for crisis situations, I may also contact emergency services or a designated emergency contact if I believe there is an imminent risk of serious harm.

COMMUNICATION OUTSIDE OF SESSIONS

Between sessions, communication should be limited to scheduling or administrative matters unless otherwise agreed. Email, text, or messaging systems are not fully secure forms of communication, and should not be used for urgent or emergency concerns.

FEES, SCHEDULING, AND CANCELLATIONS

You will be informed of current fees prior to beginning services. Payment is due at the time of service unless otherwise arranged. If you need to cancel or reschedule, please provide at least 24 hours' notice. Late cancellations or missed appointments may be charged a fee.

CLIENT RIGHTS

You have the right to:

- Participate in your treatment decisions
- Ask questions about services at any time
- Request a copy of your records, consistent with applicable law
- Request referrals or discontinue services at any time

NOTICE OF PRIVACY PRACTICES

You have been provided a separate Notice of Privacy Practices, which describes in detail how your health information may be used and your rights under HIPAA. This consent does not replace or override that Notice.

VOLUNTARY PARTICIPATION

Your participation in counseling is voluntary. You may withdraw consent for services at any time.

CONSENT TO TELEHEALTH SERVICES

By signing below, you acknowledge that you:

- Have read and understand this Telehealth Informed Consent
- Have received the Notice of Privacy Practices
- Understand the nature, risks, and limitations of telehealth services
- Voluntarily consent to receive counseling services via telehealth

I certify that I have received this Telehealth Informed Consent form for Rachel Yost, LPCC-S, LICDC. I understand that this describes the services that will be provided, my rights as a client, and information about participating in counseling via telehealth.

Client Signature: _____ Date: _____

Guardian Signature (if minor): _____ Date: _____

Client Full Name: _____

PLEASE RETURN COMPLETED FORM VIA EMAIL TO counseling@rachel-yost.com