LOIS THOMSON BOWERSOCK & associates, llc

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CLIENT INFORMATION AND CONSENT FOR DISTANCE THERAPY

Distance Therapy

Distance therapy includes the practice of mental health care delivery, diagnosis, consultation, treatment, transfer of protected health information, and education using synchronous or asynchronous audio, video, electronic devices or data communications.

Identity Verification

You will be expected to provide a copy of your driver's license and other identity verifying documentation requested by the undersigned therapist before any distance therapy services are provided.

Privacy and Security of Communications

All electronic communications between you and the undersigned therapist will be transmitted using the encryption software referenced in the *Consent to Treatment* section below. You will be responsible to secure and protect the functionality, integrity, and privacy of your hardware, files, and communication. Password protection for accessing your hardware and files is recommended. If others will be accessing the same computer or electronic device, be aware that programs exist that copy every keystroke you make. It is recommended that you schedule your sessions with the undersigned therapist when and where you can ensure the greatest level of privacy for all communications. Be sure to fully exit all programs and hardware at the end of each session.

Risks Associated With Distance Therapy

There are privacy and security risks and consequences associated with distance therapy despite the policies and procedures in place to guard against them. The risks and consequences include, but are not limited to, interrupted or distorted transmission of data or information due to technical failures and access or interception of your protected health information by unauthorized persons.

By signing this information and consent form below, you acknowledge the limitations inherent in ensuring client confidentiality of information transmitted in distance counseling and agree to waive your privilege of confidentiality with respect to any confidential information that may be accessed by an unauthorized third party despite the reasonable efforts of the undersigned therapist to arrange a secure line of communication.

Distance therapy services and care may not be as complete or effective as face-to-face services. The undersigned therapist will continually assess the appropriateness of distance therapy for you. If the undersigned therapist determines that you would be better served by receiving different therapeutic services, such as face-to-face counseling, recommendations for treatment and treatment providers or facilities will be provided to you.

Communication Interruptions

If you are unable to connect with the undersigned therapist or are disconnected during a session due to a technological breakdown, please try to reconnect within 10 minutes. If reconnection is not possible the undersigned therapist can be reached at the following phone numbers: 281-419-5255 or 281-782-6755.

Consent to Distance Therapy

I, voluntarily, agree to receive synchronous (or asynchronous) assessment, care, treatment and services through the use of the computers, iPhones, e-mail and other electronic devices with Lois Thomson Bowersock & Associates, LLC.

I agree to conduct any virtual online counseling sessions with Lois Thomson Bowersock & Associates, LLC through *Secure Video* www.securevideo.com in order to comply with HIPAA standards for protected health information (PHI). Additional information regarding the service, HIPAA compliance measures, encryption and usage of *Secure Video* is available at www.securevideo.com.

I agree to pay Lois Thomson Bowersock & Associates, LLC, $25.00 in addition to the applicable fee for my counseling session, to cover the costs of using the encrypted, HIPAA compliant services of *Secure Video*.

I acknowledge I have read and understood the security risks and potential consequences of transmitting confidential information with Lois Thomson Bowersock & Associates, LLC via e-mail, Skype, Facetime, fax, text messaging and/or any other forms of electronic transmissions.

I authorize Lois Thomson Bowersock & Associates, LLC to provide such care, treatment, or services as are considered necessary and advisable.

By signing this Distance Therapy Client Information and Consent Form, I, the undersigned client, acknowledge that I have read, understood and agreed to be bound by all the terms, conditions and information it contains. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me. I acknowledge that I received a copy of this signed Distance Therapy Client Information and Consent form from Lois Thomson Bowersock & Associates, LLC.

Client:

_____ _____

Client's Signature (Parent or Guardian if applicable) Date

As Witnessed by:

_____ _____

Witness's Signature Date

Therapist:

_____ _____

Lois Thomson Bowersock Date
LCDC, NCAC I, ADC III, ICADC, CET II