Name of Client: ________________________________

# LAUREN HOYT MA, LMFT, LISAC

**2500 N TUCSON BLVD #108 Tucson, AZ 85716 520-326-5761 x1 lauren@lhoyttherapy.com**

## Consent for Treatment via Telepractice, Couple

Tele- mental health services rely on a number of electronic, often internet based, technology tools. These tools can include telephone, videoconferencing software, email, virtual environment, specialized mobile health ("mHealth") apps, and others.

I understand that my therapist can only treat me via telepractice if I am in Arizona. If I reside in another state, it is required that my therapist be licensed in that state, as well as Arizona, and also the she complies with all the laws and rules of the jurisdiction in which I am at the time of the treatment via telepractice.

This Consent for Treatment is in addition to the general Consent for Treatment which I have already signed and specifically addresses issues which is important to me to understand regarding the procedures and the risks and benefits of treatment in this way.

There are inherent **risks** associated with telepractice. These include:

- The possibility of a breaking of confidentiality due to a non-secure electronic communication;
- Technological failure may disrupt or terminate a session, not allowing for proper closure of a session;
- Deep, more intense psychotherapeutic work may not be facilitated due to not having physical presence together;

There also can be significant **benefits**. They include:

- The ability to continue treatment temporarily if I am out of town;
- The ability to continue treatment temporarily if I move to provide time for transition;
- The ability to continue treatment if I am ill or have been exposed to a contagious disease;
- The ability to continue treatment if I do not have transportation.

I understand that the **emergency procedures** that I will , if my therapist is not available, are the same as what is recommended if I am engaged in face-to-face therapy. I can:

- Go to the nearest Emergency Room/Department;
- Contact the local Crisis Response Center (520-622-6000);
- Call 911 and request transport to the Emergency Department;

Name of Client: ________________________________

- If my therapist is on vacation, I understand that she will provide me with the name and phone number of a colleague covering for her and that my therapist encourages me to follow any recommendations followed by that covering therapist.

I understand that if telepractice is not via video, I will be asked to provide my name and date of birth in order to identify myself. If there is technology failure, I understand that my therapist will attempt to call me to confirm that there was indeed a technology failure and also to discuss transition to the next option (e.g., additional attempts(s) via the same or different technology or face-to-face). I also understand that if my therapist, believes that I am not a good fit for telepractice, she will let me know and provide a recommendation to continue therapy with another option (ie face-to-face, a covering therapist, etc).

I give my consent to utilize tele-practice when clinically warranted. I have the opportunity to ask questions about all of the issues raised above.

Signature of Client:________________________________________ Date: ____________________

Signature of Client:________________________________________ Date: ____________________

Signature of Therapist: ______________________________________Date: ____________________