Hope, Healing & Happiness Counseling Services, LLC
Kristina Cofone, LCSW
141 South Ave, Suite 101
Fanwood, NJ 07023
(908) 312-0417

I _____DOB:_____ hereby consent to engage in Teletherapy (as defined below) with Hope Healing & Happiness Counseling Services, LLC ("Provider"). I understand that "Teletherapy" may include, among other things, consultation, treatment, transfer of medical data and/or treatment related information, emails, live/real-time conversations and education using interactive audio, video, and/or data communications and platforms. I understand that in the course of my Teletherapy with Provider, details of my medical history and personal health information may be discussed and shared with myself and other behavioral health care professionals using interactive video, audio or other telecommunications technology. I hereby authorize Provider to electronically send, receive, exchange and transmit information related to my medical and behavioral health, and other treatment and service related information including in the form of images and data, through interactive video connections and/or other electronic means, to/with myself, other persons involved in my health care, and staff operating Teletherapy systems and equipment as needed. I understand and/or acknowledge the following with respect to Teletherapy:

1. I have the right to withhold or withdraw consent to engage in Teletherapy/telepsychiatry at any time without affecting my right to future care or treatment and shall notify Provider of any such withdrawal.

2. The laws that protect the confidentiality of my medical information also apply to Teletherapy. As such, I understand that the information disclosed by me during the course of my therapy or consultation is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, which are discussed in detail in the general Notice of Privacy Practices document that I received when entering treatment.

3. I understand that there are risks and consequences relating to Teletherapy, including, but not limited to the possibility that, despite reasonable efforts on the part of Provider: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted, redirected or obtained by unauthorized persons; and/or the electronic storage of my medical information could potentially be accessed by unauthorized persons, despite implementation of appropriate safeguards. It is my responsibility to maintain privacy on the client side of all communications including in connection with Teletherapy.

4. I understand that Teletherapy-based services and care may not be as complete as face-to-face, in-person services. I understand that there are potential risks and benefits associated with any form of psychotherapy. I understand that Provider Teletherapy during circumstances where face-to-face, in-person services may be difficult, impractical, or otherwise impeded, in order to ensure consistency and continuity in my treatment and avoid potential risks of gaps in my treatment. If a need for direct, in-person services arises, it is my responsibility to contact other available practitioners in my area for an in-person appointment or my primary care physician if other practitioners are not available. I understand that openings may not be immediately available.

5. I understand that I may benefit from Teletherapy, but that results cannot be guaranteed or assured.

6. I understand and accept that Teletherapy is not intended for the provision of emergency services. I acknowledge that if I am facing or if I think I may be facing an emergency situation that could result in harm to myself, or to another person, I am not to seek Teletherapy services. Instead, I agree to seek care immediately through my own local health care practitioner or at the nearest hospital emergency department or by calling 911.

7. I understand that I am responsible for (1) providing the necessary computer, telecommunications equipment and internet access for my Teletherapy sessions, (2) the data and information security on my computer and network, and (3) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my Teletherapy session. I understand that I will need access to, and familiarity with, the appropriate technology in order to participate in the service provided, and will log-in or otherwise start-up any Teletherapy platforms or

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technology used by Provider prior to my scheduled Teletherapy session in order to ensure that I am able to begin such session at the scheduled time.

8. I understand that the confidentiality and security of correspondence and/or the exchange of information via email, SMS (text) messaging, and/or certain other forms of electronic communication, including where such forms of communication are used in connection with my Teletherapy sessions, cannot be guaranteed.

9. I understand that the laws and professional standards which apply to in-person services also apply to Teletherapy services and that this document does not replace other agreements, contracts, or documentation of informed consent. This agreement shall not reduce or terminate any prior consent I have provided in connection with my treatment by Provider.

I have read this document carefully and fully understand the terms set forth herein, as well as the benefits and risks of Teletherapy services. I have had the opportunity to ask any questions that I have, and have received satisfactory answers to such questions.

With this knowledge, I voluntarily consent to participate in Teletherapy, including but not limited to any care, treatment, and services deemed necessary and advisable, under the terms described herein.

_____ _____ Date: _____

Signature of Child or Adolescent Signature of Client or Responsible Party

_____ _____

Printed name Printed name