



INFORMED CONSENT FOR ONLINE THERAPEUTIC AND/OR COUNSELING SERVICES

Colorado Christian Services (CCS) and its qualified employees, representatives and agents are offering online therapeutic and/or counseling services to meet the needs of its clients and community. Online therapy (also called "Telebehavioral Health") is rapidly growing in utilization. Online services may be satisfactory and helpful to clients in the same way that in-person therapy is. While research concerning the clinical effectiveness of individual telebehavioral health therapy has been proven, the clinical research regarding marital and family therapy online is still ongoing with early positive results. The CCS treatment provider and the client will discuss the client's needs. The CCS treatment provider will determine whether online therapeutic services are right for the client. Clients should check with their medical insurance providers to clarify whether online therapeutic services are covered.

Identity Verification

All new clients are asked to verify their age and identity by providing a scanned image of client's drivers license or other verifiable government-issued identification.

Technology

- CCS treatment providers will use HIPPA compliant video services. (e.g. Zoom or Doxy).
- CCS treatment providers will initiate the session.
- The client is responsible for securing his/ her own computer hardware, internet access, and password security.
- CCS is not liable for confidentiality breaches caused by client error.
- CCS is not responsible for the Client's equipment failure and/or failure of internet service.
- CCS is not responsible for confidentiality lapses that are a result of the client's actions.
- For further information regarding client-therapist confidentiality, please refer to the CCS Disclosure Statement.

Disconnection Problems

If a session is interrupted due to technological failures, CCS and the client will communicate by telephone in an effort to resume the online session. If the session cannot be resumed timely, the CCS provider and client will agree upon another date/ time to complete the session.

Recordings Prohibited

The client will not make an audio or video recording of the therapeutic session.

Records

- CCS Treatment Provider will maintain records of online counseling and/or consultation services.
- All clinical records will be maintained as required by the applicable legal and ethical standards according to the applicable counseling professions licensing boards.
- For further information regarding maintenance of and/or access to records, please refer to the CCS Disclosure Statement.

No Shows or Late Cancellations

A \$100 cancellation fee will apply to all missed sessions or any session that is not cancelled and/or rescheduled at least 24 hours in advance of the appointment. The cancellation fee applies to all in-person and/or online sessions.

Client and CCS Communications

CCS prioritizes and values the confidentiality of its clients. However, CCS cannot guarantee confidentiality in the dissemination of information through text or email. Communications by the CCS provider may include, but are not limited to, scheduling and/or re-scheduling appointments; giving information about CCS treatment providers and services offered; requesting statistical information regarding client; requesting payment and/or payment information from client. The conveying of therapeutically sensitive information will occur only in session. Please indicate your preference as to communications between CCS providers and Client by providing the information regarding the means by which you wish to receive and provide information, below. Please initial to indicate your consent to utilizing that particular form of communication. If you do not wish to communicate in any form indicated below, please leave that entry blank.

Client Email _____

Client Initials _____

Client Cell Phone _____

Client Initials _____

Text Message _____

Client Initials _____

Cell Phone Message _____

Client Initials _____

Other _____
(Specify Means of Communication)

Client Initials _____

Client Signature

By signing this form, I acknowledge and affirm the following:

- I am a resident of the State of Colorado.
- I understand the possible risks of engaging in online therapeutic services as described above.

However, I wish to engage in online therapeutic services.

Client Printed Name _____

Client Signature _____

Date _____