

# PINK SKIES COUNSELING, PLLC

## Client-Informed Consent for Online Counseling Services

I \_\_\_\_\_ (adult client's/guardian's name) hereby consent to engage in online counseling/teletherapy services for myself and/or my child with Cambridge Nichols, LPC-A, NCC under supervision by *Dr. Joey Achacoso, LPC-S*. I understand that online counseling/teletherapy includes consultation, treatment, transfer of medical data, emails, telephone conversations and education using interactive audio, video, or data communications. I understand that online counseling/teletherapy also involves the communication of my medical/mental information, both orally and visually.

I understand that I have the following rights with respect to online counseling/teletherapy:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment.
2. The laws that protect the confidentiality of my medical information also apply to online counseling/teletherapy. As such, I understand that the information disclosed by me during my therapy or consultation is generally confidential. However, there are limits and exceptions to confidentiality with teletherapy, just as there are with in-person therapy. I agree with these limits/exceptions and understand that my *Cambridge Nichols, LPC-A, NCC under supervision by Dr. Joey Achacoso, LPC-S* will explain these to me in detail if I wish.
3. I understand that there are risks and consequences from online counseling/teletherapy, including, but not limited to, the possibility, despite reasonable efforts on the part of *Cambridge Nichols, LPC-A, NCC under supervision by Dr. Joey Achacoso, LPC-S*, that the transmission of my information could be disrupted or distorted by technical failures.
4. I understand that if the teletherapy session does get disconnected, *Cambridge Nichols, LPC-A, NCC under supervision by Dr. Joey Achacoso, LPC-S* will call me back by phone, to complete our session.
5. In addition, I understand that online counseling/teletherapy based services and care may not be as complete as face-to-face services. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my

counselor, my condition may not be improve, and in some cases may even get worse.

6. I understand that I and/or my child(ren) may benefit from online counseling/teletherapy, but that results cannot be guaranteed or assured.
7. I accept that online counseling/teletherapy does not provide emergency services. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help; or call my primary care physician or psychiatrist. If I am having suicidal thoughts or making plans to harm myself, I can call the **National Suicide Prevention Lifeline** at **800-273-8255** for free 24-hour hotline support. I can also call the **Austin Travis County 24/7 Crisis Hotline 512-472-4357**, a uniform telecommunications system that links all ATCIC's services. Hotline clinicians offer support to anyone seeking help, identifying how they can best be served and quickly linking them with the most appropriate resources and ensuring they receive the best care possible.
8. I understand that I am responsible for (a) providing the necessary computer, telecommunications equipment and internet access for my online counseling/teletherapy sessions, (b) using Google Meet and (c) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my online counseling/teletherapy session.
9. I understand that I have a right to access my medical information and copies of medical records in accordance with HIPAA privacy rules and applicable state law.

**I have read, understand and agree to the information provided above.**

\_\_\_\_\_  
Client/Guardian Printed Name

\_\_\_\_\_  
Client/Guardian Signature

\_\_\_\_\_  
Date

Cambridge Nichols, LPC-A, NCC

Cambridge Nichols, LPC-A, NCC

Under supervision by Dr. Joey Achacoso, LPC-S  
Teletherapist Printed Name

Under supervision by Dr. Joey Achacoso, LPC-S  
Teletherapist E-Signature

\_\_\_\_\_  
Date