Amy R. Paul LPC PC
Licensed Professional Counselor
621 Street Road, Suite 1
Southampton, Pennsylvania 18966
215.354.0161
amyrpaul.lpc.pc@hushmail.com
amyrpaul.com

Telehealth Informed Consent

I, (Client Name) _____, hereby consent to participating in telehealth with Amy R. Paul LPC PC (Provider). I understand that telehealth is the practice of delivering healthcare services that include, but is not limited to, the practice of healthcare delivery, diagnosis, consultation, treatment, transfer of medical data and education using interactive audio, video or data communications between a practitioner and a client who are in two different locations. This may include, but is not limited to, interactive video conferencing, as well as communicating via telephone, text and email.

I understand the following with respect to telehealth:

Provider will use a HIPAA compliant platform for videoconferencing.

I have the right to withdraw consent at any time without affecting my right to future care, treatment, or services to which I would otherwise be entitled.

There are risks, benefits and consequences associated with telehealth, including but not limited to, the possibility, despite reasonable efforts on the part of Provider, that the transmission of my medical information could be disrupted or distorted by technical failure, the transmission of my medical information could be interrupted by unauthorized persons and/or electronic storage of my medical information could be accessed by unauthorized persons.

There will be no recording of any of the sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.

The laws that protect the confidentiality of my protected health information (PHI) also apply to telehealth.
I understand that the information disclosed by me during my therapy is confidential, with certain exceptions:
If Provider believes a client is in danger of harming him or herself, protective actions may be taken such as contacting a family member or seeking evaluation for hospitalization. If Provider believes a client is threatening serious bodily harm to another, Provider may be mandated to take protective actions including notifying the potential victim, contacting the police or seeking hospitalization for the client. If Provider believes a child is being abused, Provider is mandated to file a report with the appropriate state agency.
A judge or court may order Provider to disclose information.

I may benefit from telehealth, but that results cannot be guaranteed and that no promises have been made to me as to the results of treatment provided by Provider.

During a telehealth session, we could encounter technical difficulties resulting in service interruptions.
If this occurs, end and restart the session. If we are unable to reconnect, please call Provider at 215-354-0161.

Email/texting communication with Provider will be used for the purpose of simplifying and expediting scheduling/administrative matters only.

Any electronic communication may become a part of your legal medical record.

Email/texting communication is not to be used to provide/receive treatment services or take the place of therapy sessions.

Email/texting should not be used to communicate suicidal or homicidal thoughts or plans, urgent or emergency issues.

In a life-threatening emergency, clients are instructed to:

- call 911
- go to the nearest hospital emergency room
- call Suicide & Crisis Hotline at 1-800-273-8255

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Additional crisis phone numbers:

- Lenape Valley Mobile Crisis Intervention Services: 1-877-435-7709
- Lenape Valley Crisis Centers:
  215-345-2273 Central Bucks
  215-785-9765 Lower Bucks
- Penn Foundation Crisis Center: 215-257-6551 Upper Bucks

If I am experiencing suicidal or homicidal thoughts, psychotic symptoms, a mental health crisis or a life-threatening emergency that cannot be resolved remotely, and/or if I am abusing drugs or alcohol, it may be determined that telehealth services are not appropriate, and a higher level of care is required.
If so, I understand that Provider may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

Emergency Protocol:

Provider needs to know your location in case of an emergency. You agree to inform Provider of the address where you are at the beginning of each session. Provider needs an emergency contact person who may be contacted on your behalf in a life-threatening emergency only. This person will only be contacted to go to your location or take you to the hospital in the event of an emergency.

In case of an emergency, my location is:

My emergency contact person's name, address and phone number:

By signing below, I confirm that I have read, understood, had all my questions fully answered and agree to the terms outlined above.

*By typing your name below, you acknowledge and agree this serves as your electronic signature.

_____	_____	_____
Client Signature (14 and older)	Printed Name	Date

_____	_____	_____	_____
Parent or Legal Guardian	Printed Name	Relationship	Date

(For all clients under 18; co-signature required for clients 14-17)

_____	_____	_____	_____
Parent or Legal Guardian	Printed Name	Relationship	Date

(For all clients under 18; co-signature required for clients 14-17)

As of: 3-19-2025