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**Telehealth session log-on:**  
[doxy.me/kayciemarlerrushlcsw](https://doxy.me/kayciemarlerrushlcsw)

## **Informed Consent for Telehealth Services**

**Definition of Telehealth:** Telehealth involves the use of electronic communications to enable clinicians to connect with individuals using live interactive video and audio communications. Telehealth includes the practice of psychological health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data.

### **I understand that I have the rights with respect to telehealth:**

1. The laws that protect the confidentiality of my personal information that I have already signed also apply to telehealth. A copy of our Therapeutic Informed Consent can be provided.
2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that there are risks and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the counselor, that: the transmission of my personal information could be disrupted or distorted by technical failures, the transmission of my personal information could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons. Kay C Marler-Rush, LCSW utilizes secure, encrypted HIPAA compliant audio/video transmission software to deliver telehealth via Doxy.me.
4. I understand that due to the Coronavirus2019 and the high demand of telehealth services that Doxy.me may be unavailable and an alternative may be used such as telephone. I understand that the alternative methods may not be HIPAA compliant and the same precautions will apply.
5. Kay C (Kaycie) Marler-Rush, LCSW follows the State of Arkansas Regulations for telehealth as well as Arkansas State Social Work Board and NASW regulations and ethics. And has also received training to provide telehealth services.
6. By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio-/video-/computer-based psychotherapy services. If I am in crisis or in an emergency, I should immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in my immediate area.

### **I understand I have the following responsibilities in utilizing telehealth:**

1. I understand that it is my responsibility to be prepared and on time for my telehealth session as outlined in the Treatment Informed Consent that I have reviewed and signed.

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2. I understand that it is my responsibility to be dressed for my telehealth session as if I were attending an in-person, in-office session. I understand that if I am not appropriately dressed then my telehealth session may be rescheduled.
3. I understand that it is my responsibility to ensure I have privacy (no one else in the room) and that I will not be disturbed during my telehealth session. I will be in an appropriate living-space such as an office or living room with the door closed, or in my parked vehicle. I understand that if I do not have privacy then my telehealth session may need to be rescheduled.
4. If I am in my vehicle, it is my responsibility to ensure that it is parked and in a safe area where I will not be disturbed. I understand that if I am unable to have my vehicle parked then my telehealth session will need to be rescheduled.
5. I understand that it is my responsibility to position either my computer video camera or my phone camera at eye level to help facilitate eye contact during my telehealth session.
6. I understand that I may choose to use headphones or earbuds to enhance privacy and sound quality during my telehealth session, but it is not required.

**Payment for Telehealth Services:**

Kay C (Kaycie) Marler-Rush, LCSW will bill insurance for telehealth services when these services have been determined to be covered by an individual's insurance plan. The standard copay and/or deductibles would apply. In the event that insurance does not cover telehealth, you may wish to pay out-of-pocket, or when there is no insurance coverage. We can provide you with a statement of service to submit to your insurance company.

**Patient Consent to the Use of Telehealth:**

I have read and understand the information provided above regarding telehealth, have discussed it with my counselor, and all of my questions have been answered to my satisfaction. I have read this document carefully and understand the risks and benefits related to the use of telehealth services and have had my questions regarding the procedure explained.

I hereby give my informed consent to participate in the use of telehealth services for treatment under the terms described herein. By my signature below, I hereby state that I have read, understood, and agree to the terms of this document.

Print Name \_\_\_\_\_

Client's Signature \_\_\_\_\_ Date:

Therapist Name \_\_\_\_\_

Therapist's Signature \_\_\_\_\_ Date: