**Cassandra Kotlarchik PLLC**

Cassandra Kotlarchik, MS, LMFT, CEDS

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TELETHERAPY INFORMED CONSENT

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_consent to teletherapy with Cassandra Kotlarchik, LMFT, CEDS. I understand that teletherapy includes consultation, treatment, transfer of mental health/medical data, e-mails, telephone conversations and education using audio, video, or data communications. I understand that teletherapy includes the communication of my mental health information both orally and visually.

By signing this document, you agree that you have been informed of the following:

1. Cassandra Kotlarchik, LMFT, CEDS is licensed in Washington State only. She is only licensed to treat clients within Washington State. You agree that you are located within Washington State when receiving therapy from Cassandra and you will notify her if this changes.
2. You agree that you have access to the appropriate technology for teletherapy. This includes access to a computer, cell phone or tablet with a microphone and camera. You also agree that you have the appropriate internet connection to support teletherapy sessions.
3. You may terminate therapy at any time, just the same as face to face therapy.
4. Cassandra will follow the same confidentiality guidelines as with a face to face client. You have been informed of these guidelines in the “Therapeutic Disclosure and Policy Statement.”
5. Cassandra uses a provider called Theranest for teletherapy and keeping confidential patient records. Cassandra uses a provider called Doxy as a backup video conferencing option. Doxy and Theranest keep all information transmitted during sessions private. However, due to the complexities of the internet, there is a chance there could be a breach of your private information. You are responsible for limiting the risk of a privacy breach on your computer and Cassandra is responsible for the same on her end. By signing this agreement, you are agreeing to take the risk that your private information could be compromised via the internet, even with our precautions.
6. You are responsible for the security of your computer and the space you choose to conduct our sessions. It is recommended that you have a private space where our sessions can remain confidential and we will not be overheard. Using headphones is also recommended, to limit the amount of our session that others could overhear. Recording of sessions is discouraged because this risks your privacy.
7. Teletherapy is different from face to face therapy. In particular, teletherapy does not provide emergency services. If you are struggling with issues that Cassandra believes would be better served by face to face counseling, Cassandra will recommend you see a therapist face to face and provide you with appropriate referrals. This may include safety issues such as suicidal thoughts or thoughts of harming others.
8. Because we may live in different areas of WA, calling 911 will contact Cassandra’s local emergency department, not yours. Cassandra may need to call your local emergency number if she is concerned there is an imminent threat to your health or safety or the safety of others. For example, if you are reporting strong thoughts of harming yourself or another person, or if you have a medical emergency while in session. Please provide the following information to be used in case of emergency:

Local emergency phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address where you will be participating in sessions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Teletherapy has the limitation of not being in the room with your therapist. For some clients, it can feel more challenging to connect and build rapport with therapists when they are not in person. Please be open about your experience of teletherapy and if this is a concern for you.
2. The benefits of teletherapy include seeing a therapist who you would otherwise not be able to work with, due to distance. This may include access to therapists with specific specialties that are not available in your area. It provides convenience because you do not have travel time and may choose a setting for your sessions that works well for you.
3. Connecting for teletherapy sessions
   1. Cassandra will send you an email with a link for a Theranest video session the day of your session. Click on the link from your computer, phone or tablet and click “join.”
   2. If there are issues with Theranest, Doxy can be used as a backup. Go to <https://doxy.me/cassandrakotlarchikcounseling> from your computer

For phones, download the Doxy app and type the URL in when prompted

Type in your name and click “check in. Wait for Cassandra to start the meeting.

* 1. When using a video service online, there is the risk of connectivity issues. If we lose connection, Cassandra will call you via phone. If you do not hear from Cassandra within a few minutes, please call (425)405-2837.

1. Payment:
   1. If you are using insurance, your insurance will be billed, and you will receive an e-mailed invoice of the amount you owe after insurance coverage. You may mail cash or a check or provide credit card information over the phone. Please pay your balance within one month of receiving your invoice.
   2. If you are not using insurance, payment is due at the time of service. You may pay via credit card over the phone or during our video session. If you signed the Credit Card Authorization Form, Cassandra can charge your card with that information. If you would like to use cash or checks, please mail them after your session. Invoices will be e-mailed after each session, which will include whether you have an outstanding balance or not. You may also request superbills be e-mailed to you. You may use these to submit to your insurance company for out-of-network claims.
   3. Please mail payments to Cassandra Kotlarchik at PO Box 1662 Bothell, WA 98041.

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Client name

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Client Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent Signature Date

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Therapist Signature Date