Debra L. Kaplan Counseling
Debra L. Kaplan
MA, LPC, LISAC, CMAT, CSAT-S
6151 E. Grant Road
Tucson, Arizona 85712

Consent for Treatment - Tele-Counseling

1. Introduction

I am writing this consent for treatment in order to acquaint you with the limitations, risks and benefits of technology within a psychotherapeutic application. Further, this Consent for Treatment is an addendum to this practice's Consent for Treatment required for the practice of psychotherapy.

If this is the first time you have ever been in counseling, you may have some questions and concerns. After reading this statement please feel free to discuss any questions that you may still have which were not addressed sufficiently or at all.

I am a Master's level clinician in the practice of Counseling Psychology. I am licensed under the laws mandated by the Arizona Board of Behavioral Health Examiners. My formal education as well as previous counseling experience has prepared me to counsel individuals, families, and couples in treatment for issues coping with mental health concerns; dual diagnosis, substance abuse, and addictions.

2. Nature of Counseling and Therapy

I view my role as therapist to be a skilled and experienced clinician who works in collaboration with you to find alternative perspectives and insights to current stressors and issues in your life. The course of therapy, be it short-term or longer-term will be decided between you, the client, and myself and detailed in a treatment plan so as to make our time together productive and enduring. I look forward to working with you as you utilize new perspectives, coping skills, and/or insights in your life. *I fully expect to work myself out of a job!!!*

Guardian Signature: ______ **Date**: _____

Client Signature: _____ **Date**: _____

Therapist Signature: _____ **Date**: _____

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3. Records and Confidentiality

Any or all of our communication may become part of the clinical record. This record remains with In Balance and is in no way ethically or legally allowed to be viewed by others. Your therapeutic file is always available to you during our session. If, however, you have reason or need to view your file outside the therapy session, please call and make an appointment so that we may review your file together. There are several cases (as listed below) for which I may need to divulge information regarding our sessions.

In the case of tele-counseling, Debra Kaplan Counseling cannot guarantee nor ensure complete confidentiality. Further, I do not consider tele-therapy sessions adequate and appropriate in lieu of in office therapy. Only in specific circumstances will I agree to a HIPAA compliant platform (Tele-counseling) for therapy (See below). Those circumstances remain case specific and to be discussed at length between the client and myself.

4. The exceptions to confidentiality:

1) If I determine that you present a danger to yourself and/or others. _____

2) If you disclose to me knowledge of, or founded suspicion of ongoing child or elder abuse. At times the counselor could be subpoenaed into court to testify. _____

3) If you divulge current or past consensual or non-consensual sexual contact, sexual abuse, sexual assault or sexual exploitation of a person under the age of 18 y/o. _____

4) If you divulge past or current sexual exploitation of a person under the age of 18 y/o including knowledge of a person who knowingly downloads, streams, or accesses through any electronic, digital or print media, a film, photograph, videotape, video recording, negative, or slide in which a child is engaged in an act of obscene sexual conduct. _____

Guardian Signature: _____ **Date**: _____

Client Signature: _____ **Date**: _____

Therapist Signature: _____ **Date**: _____

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5. The exceptions to confidentiality cont'd.

5) I am ordered by a court to disclose the information as a result of a previous and/or ongoing investigation into actions taken by you, the client. _____

6) If you disclose current and/or ongoing information regarding contact with a health professional that is in violation of their ethical and legal practices. _____

7) If you direct me to disclose information for continuity of care and sign a release of information to do so. _____

6. Privacy and Confidentiality via Tele-Counseling:

1. I, _____ agree to engage in tele-counseling with the full understanding that this modality of therapy follows all requirements set forth by AZBBHE. However, due to unforeseen or external events at the location of the client, or breaches in cyber encryption and firewall confidentiality I, _____ understand and agree to the limitations of such therapy such that guarantee confidentiality cannot be guaranteed._____

2. I, _____ agree to hold harmless, Debra L. Kaplan, MA, LPC, LISAC, CMAT, CSAT-S and Debra Kaplan Counseling for any inadvertent breaches in cyber encryption and internet firewall protection. _____

3. I, _____ understand and agree that Tele-video counseling is insufficient for crisis or life threatening situations and that additional therapy may be necessary for my own safety. _____

4. In the event of an emergency a contingency referral arrangement may be required by Debra Kaplan Counseling. _____

My initials above and my signature below indicate that I understand and agree with the terms set forth in this consent for treatment.

Client Signature_____ Date _____

Therapist Signature _____ Date _____