DONNA W. UPCHURCH, PhD, LMFT, APN, CNS
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~ Telehealth Consent ~

I ____ hereby consent to engage in telehealth therapy with Donna W. Upchurch, PhD. I understand that telehealth includes consultation, treatment, transfer of medical data, emails, telephone conversations and education using interactive audio, video, and data communications. I understand that telehealth therapy also involves the communication of my medical/mental health information, both orally and visually.
I understand that I have the following rights with respect to telehealth therapy:
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 telehealth therapy. As such, I understand that the therapist/client relationship is a confidential one. However there is only limited confidentiality privilege under South Carolina law. Exceptions are as follows:

- South Carolina law requires all mental health professionals to report any suspected or known child or elder abuse or neglect.
- South Carolina law also requires all mental health professionals to report any threat of harm to self or others.
- While a therapist is not required to respond to a subpoena, under particular circumstances a judge may issue a Court Order mandating a therapist to testify and/or relinquish records in legal proceedings. This is a rare occurrence.

3. I understand that there are risks and consequences from telehealth therapy, including, but not limited to, the possibility, despite reasonable encryption efforts on the part of Dr, Upchurch that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.
4. In addition, I understand that telehealth therapy based services and care may not be as complete as face- to-face services. I also understand that if Dr. Upchurch believes I would be better served by another form of therapeutic services (e.g. face-to-face services) I will be assisted in scheduling a face to face appointment with Dr. Upchurch or I will be referred to a professional who can provide such services in my area.
5. I understand that I may benefit from telehealth therapy, but that results cannot be guaranteed or assured.
6. I accept that telehealth therapy does not provide emergency services. During our first session, Dr. Upchurch and I will discuss an emergency response plan. If I am experiencing an emergency situation, I understand that I can call 911 or proceed to the nearest hospital emergency room for help. If I am having suicidal thoughts or making plans to harm myself, I can call the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) for free 24 hour hotline support. I understand for a non-emergency crisis I may be asked to attend a face-to-face appointment with Dr. Upchurch.
7. I understand that **I am responsible for (1) providing the necessary computer, telecommunications equipment and internet access for my teletherapy sessions, (2) the**

information security on my computer and other relevant electronic devices, and (3) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my tele-therapy session.

8. I understand that in the event of technological failure Dr. Upchurch will attempt to work with me to immediately reestablish connection. If I am uncertain how to proceed I can call or text her at 803-603-4700. I will receive the full benefit of my scheduled session.
9. I understand that in the event of an emergency or need to reschedule/cancel I am free to call/text (803-603-4700) or email (donna@watereecounseling.com) Dr. Upchurch between sessions as necessary. I agree to keep between session contacts to a minimum, however.
10. I understand that while email or text may be used to receive appointment reminders, confidentiality of emails and texts cannot be guaranteed.
11. I understand that Dr. Upchurch is licensed and bound by the ethical code of the American Association for Family Therapy and the American Nurses Association.
12. 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.

Patient Signature ____

Printed Name ____

Date ________________

Donna W. Upchurch, PhD, APN, CNS
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SC License #4010 APN
CNS License #0098089