John Cutrone, LMHC, LLC
6810 Lyons Technology Circle, Suite 125, Coconut Creek, FL 33073
Phone: (561) 289-9722 Fax: (561) 544-7149 Website: www.CutroneLMHC.com

Technology Assisted Counseling Addendum and Agreement

I _____(Print Client Full Legal Name) hereby consent to engage in teletherapy, or Technology Assisted Counseling (TAC), with John Cutrone, LMHC, MCAP, A-CAS (Provider). I understand that TAC includes consultation, treatment, transfer of medical data, emails, telephone conversations and education using interactive audio, video, or data communications. I understand that TAC also involves the communication of my medical/mental health information, both verbally and visually. This form is in addition to the Notice of Privacy Practices (HIPAA) form signed at admission.

I (Client) understand that I have the following rights with respect to TAC:

1. I understand that John Cutrone, LMHC, MCAP, A-CAS, is licensed solely in the state of Florida, and can only provide TAC services to residents physically residing in Florida. You agree to inform me if your therapy location has changed or if you have relocated your domicile to a different jurisdiction. I also understand that I MUST specify the location (and full address) where I am receiving TAC at each visit with Provider. Failure to disclose location will result in the session being ended.
2. I understand that the laws that protect the confidentiality of my protected health information also apply to TAC. As such, I understand that the information disclosed by me during the course of my therapy or consultation is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality (such as suspected abuse or neglect of children/elders, or risk of harm to myself or others). Should one of these concerns arise, I understand that provider must break confidentiality and notify the proper authorities.
3. I understand that unless I am an established client of the Provider already, an assessment, and subsequent sessions if necessary, may first be required to be in-person to determine appropriateness for TAC. I understand that the Provider is in no way obligated to provide TAC, and may recommend continuing or reverting back to in-person therapy sessions if he determines it to be clinically appropriate.
4. **Emergencies:** I understand that TAC is not utilized for Crisis Services. During our assessment/session to determine appropriateness for TAC, the Provider and I will discuss an emergency response plan as well as emergency contacts. If I am experiencing an emergency situation prior to or after a TAC session, I understand that I will follow the emergency response plan and utilize the resources below.

   If I am having suicidal thoughts or am making plans to harm myself or someone else, I can call the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) for free 24 hour hotline support, or text HELP to 741741. If an Emergency concern arises *during* a TAC session, I understand that the Provider is mandated to break confidentiality and call 911/local emergency services/emergency contacts in my area to insure my safety.

5. **Technology:** I understand that I am responsible for providing the necessary computer, telecommunications equipment and high-speed internet access for my TAC sessions. I'm also responsible the security of the information on my computer.
6. **HIPAA-Compliant Service:** I agree to utilize the Doxy.me website and/or smartphone/tablet App. John Cutrone, LMHC, MCAP, A-CAS utilizes Doxy.me to facilitate TAC sessions as it is a HIPAA-

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compliant telehealth service. Other services such as Skype, FaceTime, Google Hangouts, etc. are not considered secure/compliant with HIPAA, and will not be utilized under any circumstances.

7. **Recording:** I understand that any recording, screenshots, etc. of the TAC session is not be permitted and are grounds for termination of the client-therapist relationship.
8. **Privacy:** I understand that TAC is best conducted in an environment with sufficient lighting and privacy that is free from distractions or intrusions for my TAC session. I also understand that if I choose to be in a place where others may be able to see or hear me during the TAC session, the Provider cannot be held responsible for protecting my confidentiality. I will make every effort to protect my confidentiality in the setting I choose. I understand that a headset may help increase privacy, as well as the ability to hear/be heard in session. The Provider will call from a private location where he is the only one in the room.
9. **Payment:** I understand that payment of session fees and/or insurance copayments and deductibles will be collected at the beginning of session via credit card and must be paid before services are rendered. I am also responsible for fees/services not covered by insurance, if applicable.
10. **Cancellation:** I understand that the cancellation policy agreed upon in the informed consent forms at admission also apply to TAC. 24-hour advanced notice is required, and failure to attend your TAC session or cancellation under 24-hours is subject to the cancellation fee outlined at admission. Cancellations must be communicated by phone rather than email or text.

At least 1 Current Emergency Contact is Required on-file at all times prior to participate in TAC. I authorize the Provider to contact the following person only in the case of emergencies that may arise prior-to, during, or after a telehealth session to ensure my safety. I will also update this emergency contact if anything changes.

Emergency Contact:

Full Legal Name: _____

Relationship to Client: _____

Phone number(s): _____

I have read, understand, and agree to the information provided above.

_____	_____	_____
Printed Name of Client (or legal guardian if minor)	**Signature of Client (or legal guardian)**	**Date**
John Cutrone, LMHC, MCAP, A-CAS	_____	_____
Printed Name of Therapist	**Signature of Therapist**	**Date**