



# Coastal Samaritan Counseling Center

## *Instilling hope and healing*

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## Video Therapy Services Disclosure

### **VIDEO THERAPY SERVICES:**

CSCC offers Video Therapy Services (VTS) to delivery health care services using electronic communications to connect with individuals using interactive video and audio communications. The laws that protect confidentiality of your personal information also apply to Video Therapy Services. We take privacy and security very seriously. As a result, the VTS platform used by CSCC complies with HIPAA requirements. CSCC utilizes secure, encrypted audio/video transmission platforms to deliver VTS.

I understand that I have the rights with respect to Video Therapy Services:

1. The laws that protect the confidentiality of my personal information also apply to VTS. As such, I understand that the information disclosed by me during the course of my sessions is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to, reporting child, elder, and dependent adult abuse; expressed threats of violence toward an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding. I also understand that the dissemination of any personally identifiable images or information from the VTS interaction to other entities shall not occur without my written consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of online therapy 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 VTS, 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.
4. I understand that if my counselor believes I would be better served by another form of intervention (e.g., face-to-face services), I will be referred to a face-to-face intervention if available with my counselor or referred to mental health professional that can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my counselor, my condition may not improve, and in some cases may even get worse.
5. I understand the alternatives to counseling through VTS as they have been explained to me, and in choosing to participate in VTS, I am agreeing to participate using video conferencing technology. I also understand that at my request or at the direction of my counselor, I may be directed to “face-to-face” psychotherapy.

6. I understand that I may expect the anticipated benefits such as improved access to care and more efficient evaluation and management from the use of online therapy in my care, but that no results can be guaranteed or assured.
7. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. I understand that the VTS provided by Coastal Samaritan Counseling Center falls under the policies and procedures already in place which was provided as part of this intake process including, the therapy process, your rights as a client, confidentiality, fees and payment, appointments and cancellation, insurance and other third-party party payment and ending therapy.
8. 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.

PATIENT CONSENT TO THE USE VIDEO THEAPY SERVICES: I have read and understand the information provided above regarding VTS, 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 online therapy services and have had my questions regarding the procedure explained. I hereby give my informed consent to participate in the use of online therapy 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.

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Print Client Name

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Client Signature

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Date