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THERAPY SERVICES LLC

Telehealth Consent Form

I understand that Telehealth is a mode of delivering health care services, including psychotherapy, via secure video conferencing to facilitate diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care.

By signing this form, I understand and agree to the following:

1. I understand that I have a right to confidentiality with regard to my treatment and related communications via Telehealth under the same laws that protect the confidentiality of treatment information during in-person psychotherapy.

2. I understand that there are potential risks involving technology, including but not limited to internet interruptions and technical difficulties. I understand that technical difficulties with hardware, software, and internet connection may result in service interruption and that the health care provider is not responsible for any technical problems and does not guarantee that services will be available or work as expected.

3. I understand that there are risks associated with participating in Telehealth including, but not limited to, the possibility, despite reasonable efforts and safeguards on the part of my therapist, that my psychotherapy sessions and transmission of my treatment information could be disrupted or distorted by technical failures and/or interrupted or accessed by unauthorized persons, and that the electronic storage of my treatment information could be accessed by unauthorized persons.

4.I understand that telehealth has potential benefits including easier access to care and the convenience of meeting from a location of my choosing. However, I also understand that I am responsible for information security on my computer and in my own physical location. I understand that I am responsible for ensuring the privacy of my own location by being in a location where other individuals cannot hear my conversation. I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

5. I understand that at the beginning of each Telehealth session my therapist is required to verify my full name and current location.

6. I understand that in some instances Telehealth may not be as effective or provide the same results as in-person therapy. I understand that if my therapist believes I would be better served by in-person therapy, my therapist will discuss this with me and refer me to in-person services as needed. I understand that my healthcare provider or I can discontinue teletherapy services if it is felt that this type of service delivery does not benefit my needs.

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7. I understand that some Telehealth platforms allow for video or audio recordings and that neither I nor my therapist may record the sessions without the other party's written permission.

8. I have discussed the fees charged for Telehealth with my therapist and agree to them, and I have been provided with this information in the Informed Consent Form.

9. I understand that my therapist will make reasonable efforts to ascertain and provide me with emergency resources in my geographic area. I further understand that my therapist may not be able to assist me in an emergency situation. If I require emergency care, I understand that I may call 911 or proceed to the nearest hospital emergency room for immediate assistance.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

_____
Client Name (Printed)

_____
Client Signature

_____
Date