Teletherapy Informed Consent Form

Client Name: _____

I, _____, hereby consent to participate in teletherapy services provided by a licensed mental health provider, Alison Goldberg, LPCC 3503.

By signing this form, I acknowledge and agree with the following:

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1. Consent to Teletherapy

- I authorize the electronic transfer of information regarding my medical and mental health care through an interactive video connection.

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2. Session Transparency

- I understand that I will be informed of the identities and roles of any individuals present during my teletherapy sessions.

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3. Technology and Treatment

- My provider has explained how the teletherapy system functions and how it will be used in my treatment.
- I have been informed of the differences between teletherapy and in-person sessions, including any emotional reactions that may occur due to the use of technology.
- I understand that my provider will not be physically present, and our interaction will occur via secure electronic communication.

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4. Risks and Limitations

- I understand that teletherapy is a developing method of providing mental health services and that certain risks may not yet be fully known.

- Possible risks include, but are not limited to:
    - Occasionally unclear or inadequate video/audio quality,
    - Potential disconnection or technical disruptions,
    - Rare instances of unauthorized interception of information.

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5. Confidentiality and Privacy

- I agree to take necessary precautions to ensure the privacy of my teletherapy sessions, such as participating from a secure and confidential location.
- I understand that my teletherapy sessions are protected under HIPAA privacy laws, and I may request a copy of my electronic records in writing.

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6. Insurance and Information Sharing

- I authorize the release of information related to my treatment, as deemed necessary by my provider or insurance company, for the purpose of billing and claims processing.

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7. Right to Discontinue

- I may choose to discontinue teletherapy services at any time. Upon such a decision, my provider will offer a referral to a local mental health professional for in-person services if needed.

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8. Emergency and Safety Protocols

- I understand that, under applicable law, my provider is obligated to report any information suggesting that I may pose a danger to myself or others.
- In the event of an emergency, I authorize my provider to contact the following individuals:

Emergency Contact Information:

- **Emergency Contact (Family Member or Personal Contact):**

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9. Acknowledgement

- My provider has reviewed the risks, benefits, and alternatives to teletherapy services with me.
- I understand that I may still need to consult a specialist in person, depending on my clinical needs.

Provider Contact Information:

- **Name:** __Alison Goldberg, LPCC 3503_____
- **Email:** ____alison@yoursoberfuture.com_____
- **Phone:** _____818.314.3187_____

Consent to Participate

I voluntarily consent to receive tele-mental health services using videoconferencing technology for the purposes of care, treatment, and services as outlined above.

Client Name (Printed): _____

Client Signature: _____

Date: _____