Strength of Life Counseling Services

TeleHealth Disclosure and Consent Form

Telehealth allows my therapist to diagnose, consult, treat and educate using interactive video communication regarding my treatment. I hereby consent to participating in psychotherapy via the internet (hereinafter referred to as Telehealth) with the clinician listed below:

Client Name: _____

Clinician: _____

I understand I have the following rights under this agreement:

I have a right to confidentiality with Telehealth under the same laws that protect the confidentiality of my medical information for in-person psychotherapy. Any information disclosed by me during the course of my therapy, therefore, is generally confidential.

There are, by law, exceptions to confidentiality, including mandatory reporting of child, elder, and dependent adult abuse and any threats of violence I may make towards a reasonably identifiable person. I also understand that if I am in such mental or emotional condition to be a danger to myself or others, my therapist has the right to break confidentiality to prevent the threatened danger. Further, I understand that the dissemination of any personally identifiable images or information from the Telehealth interaction to any other entities shall not occur without my written consent.

I understand that while psychotherapeutic treatment of all kinds has been found to be effective in treating a wide range of mental disorders, personal and relational issues, there is no guarantee that all treatment of all clients will be effective. Thus, I understand that while I may benefit from Telehealth, results cannot be guaranteed or assured.

I further understand that there are benefits and risks unique and specific to Telehealth, including but not limited to, the possibility that our therapy sessions or other communication by my therapist to others regarding my treatment could be disrupted or distorted by technical failures or could be interrupted or could be accessed by unauthorized persons. I understand that it is my responsibility to find a private space for Telehealth sessions and to ensure that no other individuals listen or join the session without therapist awareness and consent.

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Telehealth provides convenience and flexibility for both clients and therapist, and the ability to meet regardless of weather or other factors that make it difficult to attend in person. It also provides greater privacy and the ability to meet in the comfort of a client's home. I understand that Telehealth treatment is different from in-person therapy and that if my therapist believes I would be better served by another form of psychotherapeutic services, such as in-person treatment, I will be referred to a therapist in my geographic area that can provide such services.

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 911 or go to the nearest hospital or crisis facility. By signing this document I understand that emergency situations may include thoughts about hurting or harming myself or others, having uncontrolled psychotic symptoms; if I am in a life threating or emergency situation, and/or if I am abusing drugs or alcohol. By signing this document, I acknowledge I have been told that if I feel suicidal I am to call 911, local county crisis agencies or the National Suicide Hotline at 1-800-784-2433.

I have read and understand the information provided above. I have the right to discuss any of this information with my therapist and to have any questions I may have regarding my treatment answered to my satisfaction.

I understand that I can withdraw my consent to Telehealth communications by providing written notification. My signature below indicates that I have read this Agreement and agree to its terms.

Signed: _____ Date: _____