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1. Informed Consent for Psychotherapy & Telehealth

General Information and Informed Consent

The therapeutic relationship is a contractual agreement that is unique and highly personal. Therefore, it is important to have a clear understanding about our relationship and what each of us can expect. This consent will provide a framework for our work together. Please read and indicate that you have reviewed this information and agree to it by initialing at the end of this document.

The Therapeutic Process

The outcome of your treatment depends largely on your participation in this process, which may, at times, result in discomfort. Discussing unpleasant events and the emotions attached to those events can cause feelings of anger, depression, anxiety, and so forth. Although I can't guarantee that your behaviors or circumstances will change, I can support and do my very best to understand you, as well as to help you clarify your change goals.

Confidentiality

The session content and all relevant treatment materials will be held confidential unless the client requests, in writing, to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below:

• If a client threatens or attempts to commit suicide or otherwise conducts him/her self in a manner in which there is a substantial risk of incurring serious bodily harm.

• If a client threatens grave bodily harm or death to another person.

• If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.

• Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.

• Suspected neglect of the parties named in items #3 and # 4.

• If a court of law issues a legitimate subpoena for information stated on the subpoena.

• If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

Telehealth

To better serve the needs of the community, health care services are now available by telephonic, interactive video

communications, and/or by the electronic transmission of information. This process is referred to as "telehealth." Telehealth involves the use of electronic communications to enable healthcare delivery, diagnosis, treatment, transfer of medical data, therapy, consultation, follow-up and/or education.

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption. Since this may be different than the type of consultation with which you are familiar, it is important that you understand and agree to the following statements.

By signing this form, I understand the following:

• I understand that the laws that protect privacy and the confidentiality of medical information also apply to Telehealth.

• I understand that the information disclosed by me during the course of my treatment is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including but not limited to information demonstrating a probability of imminent physical injury to myself or others; immediate mental or emotional injury to myself; 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 Telehealth interaction to researchers or other entities shall not occur without my consent.

• I understand that I have the right to withhold or withdraw my consent to the use of Telehealth in the course of my care at any time, without affecting my right to future care or treatment.

• I understand that I have the right to inspect all information obtained and recorded in the course of a Telehealth interaction, and may receive copies of this information for a reasonable fee.

• I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. I understand that I may ask my Treatment Provider about alternative methods of care to Telehealth.

• I understand that Telehealth may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out-of-state.

• I understand that it is my duty to inform my Treatment Provider of electronic interactions regarding my care that I may have with other healthcare providers.

• I understand that Telehealth based services and care may not be as complete as face-to-face services.

• I also understand that if my Treatment Provider believes I would be better served by another form of service (e.g. face-to-face services), I will be referred to a Treatment Provider who can provide such services in my area.

• Finally, I understand that there are potential risks and benefits associated with any form of treatment, and that despite my efforts and the efforts of my Treatment Provider, my condition may not improve, and in some cases may even get worse.

• I understand that I may expect the anticipated benefits from the use of Telehealth in my care, but that no results can be guaranteed or assured.

• I understand that in the event of an adverse reaction to the treatment, or in the event of an inability to communicate as a result of a technological or equipment failure, I shall seek follow-up care or assistance at the recommendation of my Treatment Provider.

In cases of emergency, do not use Treatment Provider. Instead, call 911 immediately. Complaints may be reported for investigation to the appropriate licensing board of the state in which the client received the services.

Client Consent to the Use of Telehealth

I have read and understand the information provided above regarding Telehealth and understand I have the opportunity to discuss it with my Treatment Provider or such assistants as may be designated. I hereby give my informed consent for the use of Telehealth in my medical care.

Furthermore, I agree that the Released Parties have no liability or responsibility for the accuracy or completeness of the medical information submitted to them or for any errors in its electronic transmission.

Client's Initials::

Date::