Embrace Healing Therapy Center, LLC
Emileah Most, MS, LMFT

TELEHEALTH INFORMATION AND INFORMED CONSENT

Client Name ___________________________________ Client Date of Birth _____/_____/______

Telehealth Information:

Telehealth/Telemental health/Teletherapy is live two-way audio and video electronic communications that allows therapists and clients to meet outside of a physical office setting.

Client Understanding:

I understand that the telehealth services are completely voluntary and that I can withdraw this consent at any time.

I understand that none of the telehealth sessions will be recorded or photographed.

I agree not to make or allow audio or video recordings of any portion of the sessions.

I understand that the laws that protect privacy and the confidentiality of client information also apply to telehealth, and that no information obtained in the use of telehealth that identifies me will be disclosed to other entities without my consent.

I understand that telehealth is performed over a secure communication system that is almost impossible for anyone else to access. I understand that any internet-based communication is not 100% guaranteed to be secure.

I agree that the therapist and practice will not be held responsible if any outside party gains access to my personal information by bypassing the security measures of the communication system.

I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties.

I understand that I or my therapist may discontinue the telehealth sessions at anytime if it is felt that the video technology is not adequate for the situation.

I understand that if there is an emergency during a telehealth session, then my therapist may call emergency services and/or my emergency contact.

I understand that this form is signed in addition to the Privacy Practices and Therapy Agreement and that all policies and procedures apply to telehealth services.

I understand that if the video conferencing connection drops while I am in a session, I will have an additional phone line available to contact the therapist, or I will make additional plans with my therapist ahead of time for re-contact.

I understand a “no show” or late fee will be charged if I miss an appointment or do not cancel within 24 hours of a scheduled appointment. I understand credit card or other form of payment will be established before the first session.

I understand my therapist will advise me about what telehealth platform to use and she will establish a video conference session.

Client Signature ____________________________________ Date ___________